NEWS RELEASE

For release 11 a.m.
April 7, 2006

BC Children and Youth Review
Hon. Ted Hughes, OC, QC, LL.D. (Hon.)

HUGHES CALLS FOR STABILITY IN B.C. CHILD PROTECTION

VICTORIA – Upheavals to a child protection system that has been stretched far beyond its limits must stop, the Hon. Ted Hughes said today in publicly releasing the final report from his independent B.C. Children and Youth Review.

"My strongest impression from this review is one of a child welfare system buffeted by an unmanageable degree of change," Hughes said. "The need for equilibrium and stability is a central theme of my report.

"In the best interests of our province's most precious assets -- our children and youth -- I call upon all members of B.C.'s government to move towards substantial compliance with the recommendations in my report."

A revolving door in senior leadership positions, major shifts in practice, functions, and processes, and significant funding cuts have created a climate of instability and confusion that has only detracted from the Ministry of Children and Families' work on behalf of children, Hughes said.

Hughes is calling for the appointment of a new, independent body to oversee the child welfare system. The Representative for Children and Youth would be appointed as an Officer of the Legislature for a five-year term, and report to an all-party Standing Committee.

"I encourage the introduction of legislation this fall to enable the timely appointment of the Representative for Children and Youth, who can begin addressing some of the very real challenges facing the province," Hughes said.

The Representative would have the authority to advocate for individual children and families, advocate for systemic change, monitor and report on the child welfare system, and review child injuries and deaths. The focus would be more on examining patterns and trends of injuries and deaths in the child welfare system, and less on individual child death reviews, to continuously learn and improve policies, practices and services to children and youth.

Hughes' report also highlights the unique situation of Aboriginal children and families in B.C.'s child protection system.

"I am disheartened by the rate of suicide among young Aboriginal people and the ever-increasing numbers of Aboriginal children being taken into care," Hughes said. "Immediate measures are recommended to strengthen current Aboriginal delegated agencies, so that they are able to carry out their child welfare responsibilities as effectively as possible."

...2/

The needs are simple but acute, such as office management systems and skills, computer equipment and Internet access to track cases and communicate quickly with other agencies. As well, access to the same training opportunities provided to Ministry staff, and to special training directed to their particular needs, is essential, he said.

"We have an opportunity now to build on commitments made in the Kelowna Accord, and its focus on housing, education, health and economic opportunity," Hughes said. "We are in a better position than ever to close the gap in the quality of life enjoyed by Aboriginal people and other British Columbians, and start reversing conditions that cause so many Aboriginal children to need protection."

The Hughes report also includes an examination of the transfer of the child death review function and related child death files when the Children's Commission office was closed in 2002.

"We've done a thorough review of these files and I'm satisfied with the current status of the Coroners Service review of the transition files," Hughes said, adding that Coroner's investigations are now complete on two-thirds of the files. The Coroner intends to have all reviews completed by September 2006.

During the Hughes review, 955 files were identified, located, and inspected. That includes 249 files that were not included in the Ministry's original count because Coroners reviews on them were already complete at the time the Hughes process began.

Recommendations include having the new Representative for Children and Youth prepare a special report examining information relating to the files of those children who had been in care or receiving ministry services.

Hughes, appointed in November 2005 to carry out his child protection review, said he believes the B.C. Children and Youth Review report and its 62 recommendations form a blueprint for full repair of a system caring for the province's most vulnerable children and families.

- 30 -

Highlight sheet attached.

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For more information, full report and related documents, visit the Review's website at www.childyouthreview.ca

HIGHLIGHTS

For release 11 a.m.
April 7, 2006

BC Children and Youth Review
Hon. Ted Hughes, OC, QC, LL.D. (Hon.)

THE REPRESENTATIVE FOR CHILDREN AND YOUTH:

As an independent Officer of the Legislative Assembly, the Representative should be appointed for a five year term, report to a Legislative Standing Committee established to address issues of children and youth, and:

- provide individual advocacy support, with a regional focus, to support dispute resolution.
- monitor and undertake broader systemic reviews and make recommendations enhancing child welfare.
- have two Deputy Representatives, one for advocacy and one for monitoring the child welfare system. At least one of these three senior people should be Aboriginal.
- review injuries and deaths in the child welfare system, where warranted, with an enhanced focus on analysis of trends and patterns, to inform public health and prevention.

Introduction of legislation in the fall session to enable establishment of this office is recommended.

ADVOCACY:

Child and family advocacy in BC has suffered in recent years. There is strong support for the provision of advocacy services: for individuals, and more broadly for positive change in policies, practices and services.
This should include a regional presence, to help children, youth and their families find their way through the system, and to make sure their voices are heard and considered.

ABORIGINAL CHILDREN:

The ever-increasing numbers of Aboriginal children being taken into care highlights the pressing need for the child welfare system to pay attention to Aboriginal perspectives, and find better ways to respond to their needs.

Aboriginal people alone truly understand their communities and the needs of their children and families. It makes sense that their own wisdom and understanding should guide the way to any change in the governance structure of the child welfare system that serves them, in partnership with the support and experience of the Ministry.

Recommendations also include immediate measures to strengthen current Aboriginal delegated agencies, such as office management skills, computer equipment, Internet access to track cases and communicate quickly with other agencies, and access to basic and specialized training opportunities.

LEARNING FROM AND IMPROVING ON CHILD INJURY AND DEATH REVIEWS:

In the aftermath of the tragic death of a child, what is sometimes lost sight of is that the death rate among children in British Columbia is declining and has been for years.

Sadly, children will continue to die. Every child's death diminishes us all, and every child's unexpected death needs to be carefully examined.

The report recommends an enhanced public health perspective, with a greater emphasis on looking at trends and patterns of deaths and critical injuries, and less emphasis on individual reviews of deaths.

GOVERNMENT ACCOUNTABILITY:

Government has a responsibility to be accountable to the public for its performance in protecting and serving children and youth.

The Ministry needs a regular, coordinated program of public reporting on its activities and the results achieved for children in care and children at risk. This must include Ministry accomplishments and successes.

The Hughes review recommends that Ministry annual reports provide a statistical analysis of its death reviews and critical incidents, as well as resulting recommendations and progress on implementation.

DECENTRALIZATION:

Decentralizing child welfare programs means involving local communities in service delivery and resource allocation, to better address the needs of children and their families. The report supports the move to decentralization, but only if important guidelines are respected. The move to decentralize services and authorities to the regions, and eventually to Aboriginal governance authorities, poses many challenges.

It is recommended government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stabilization.

955 TRANSITION FILES:

Hughes said he is satisfied with the current status of the Coroners Service review of the transition files.

The review's examination confirmed that:

- 539 files were active at the time the Children's Commission office closed
- During the transition period of transferring responsibility for child death reviews to Coroner's Service, 416 child deaths were recorded in the database.

Coroner's investigations have now been completed on two-thirds of the files, and the Coroner intends to have all reviews completed by September 2006.

The report recommends having the new Representative for Children and Youth prepare a special report examining any patterns or trends relating to the files of those children in the 955 transition files who had been in care or receiving Ministry services.

106-04231/

BRITISH
COLUMBIA

STATEMENT

Ministry of Children and Family Development

For Immediate Release
2006CFD0007-000401
April 7, 2006

MINISTER RESPONDS TO B.C. CHILD AND YOUTH REVIEW

VICTORIA – Children and Family Development Minister Stan Hagen issued the following statement today:

"I am very pleased with this balanced, fair and thoughtful review presented by Hon. Ted Hughes.

"Together with my colleagues, I will spend the coming days looking in detail at Mr. Hughes' recommendations and his plan. We will move expeditiously, but carefully. He has set out a reasonable timeframe to act on his recommendations. Where we can act faster, we will.

"Commenting on the review itself, we are pleased that it is forward looking, constructive and focused on continual improvement in our protection of children. It is not looking to turn back the clock to an old system of overlapping mandates and duplication that was not meeting the best interests of children.

"On balance, the report provides a blueprint that builds on the fundamental vision, direction and changes government implemented since 2001 to improve child protection and reporting. He supports the mandate we gave the Coroner's Office to review child deaths, and the role of the ministry in reviewing deaths and injuries of children under its watch.

"Mr. Hughes acknowledges that the ministry has accomplished a great deal and endorses the resources provided in Budget 2006, as well as our initiatives such as bringing supports and services closer to communities and keeping families together.

"His support of initiatives such as the Kelowna Accord and Aboriginal governance echoes this government's firm commitment to improving quality of life for Aboriginal people and fostering a new relationship with their communities.

"We acknowledge Mr. Hughes' comments about areas where the ministry has struggled, and agree that the ministry can do better. We will do better and we have the resources and dedicated people to follow through. We will work collaboratively with our partners: this means our Aboriginal partners, our community partners and our federal partners. This will not happen overnight, but it will happen.

"We endorse Mr. Hughes' call for the spirit of co-operation among legislators to do what's best for children and youth. Only by working together will we be able to move forward in their best interests.

-more-

"I thank Hon. Ted Hughes and his team as well as the organizations and individuals who made submissions. I also thank staff within my ministry who also provided much time and effort in responding to the needs of the review."

-30-

1 backgrounder(s) attached.

Media contact:	Kelly Gleeson Communications Director 250 356-2007 250 361-6313 (cell)

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BACKGROUNDER

2006CFD0007-000401
April 7, 2006

Ministry of Children and Family Development

NEW FUNDING & NEW INITIATIVES EQUAL ENHANCED SERVICES

Following a Ministry of Children and Family Development budget increase of $80 million in 2005/06, Budget 2006/07 provides $273 million in additional funding to assist the ministry in carrying out its mandate to protect the health, safety and well being of B.C. children. Of that total, $100 million has been earmarked over the next three years to give government the flexibility to respond to recommendations from the current external reviews.

Programs specifically targeted to children at risk include:

- New approaches to working with families, such as mediation and family group conferences;
- Additional resources for grandparents and other relatives looking after children under kith and kin agreements; and
- More social workers and other front-line staff to help vulnerable families and children and youth at risk.

Specifically, in this fiscal year:

- A $22-million increase for children at risk. This includes supports for caregivers, families and staffing;
- An additional $20 million for children and family services; and
- $14.3 million in additional funding for the Child and Youth Mental Health Plan (in addition to a $12.7-million increase in 2005/06).

The Ministry of Children and Family Development has also initiated a number of measures aimed at improving the speed and thoroughness with which case reviews are conducted – and to improve management information to stay on top of reports and analysis.

- A recruitment process is underway that will lead to additional staff in the regions and at headquarters to speed up the process of completing reviews and monitoring performance.
- MCFD is clarifying policy around the types of reviews that are conducted and when and how they are conducted, how recommendations are developed and recording reasons when a review will not be conducted.
- Enhancing mentoring and training programs for specialized social workers to complete case reviews.
- Strengthening the way we monitor the ministry's work performance (what the ministry refers to as Quality Assurance).
- Building a new framework for monitoring the progress of Child Death Reviews, including reporting on progress to the ministry's executive.
- Implementing a new management information system to track and share information relating to fatalities, critical incidents and recommendations.
- Reviewing standards to assess the readiness of any new agency to deliver child welfare services.

-30-

Media contact:	Kelly Gleeson 250 356-2007 250 361-6313 (cell)

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BC Children and Youth Review

Honourable Ted Hughes OC, QC, LL.D. (Hon.)

An Independent Review of BC's Child Protection System

April 7, 2006

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BC Children and Youth Review

Honourable Ted Hughes OC, QC, LL.D. (Hon.)

An Independent Review of BC's Child Protection System

April 7, 2006

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April 7, 2006

Honourable Stan Hagen
Minister of Children and Family Development
The Province of British Columbia

Dear Minister:

I am pleased to submit the BC Children and Youth Review final report.

I was appointed to conduct an independent review of British Columbia's child protection system. As per my Terms of Reference, this report includes recommendations to improve:

- Monitoring and publicly reporting of the government's performance in protecting and providing services for children and youth in British Columbia,
- Advocacy for children and youth,
- The system for the review of child deaths, including how the reviews are internally addressed, and
- The public reporting of child death reviews to ensure that it balances the need for public accountability with the privacy interests of the families and others involved.

The safety and well-being of B.C.'s children, youth and families are at the centre of this report. I ask that you and all Members of the Legislative Assembly give positive consideration to what is being recommended.

Sincerely,

Honourable Ted Hughes, OC, QC, LL.D. (Hon.)
Victoria, British Columbia

Contents

1. FIRST WORDS 3
1.1 What Led To This Review? 5
1.2 My Review 8
1.3 How I Conducted This Review 10
1.4 Where We Are Today 13
1.5 This Report 14
2. A NEW PLAN FOR EXTERNAL OVERSIGHT 21
2.1 A Learning Process 22
2.2 A New Representative for Children and Youth 29
2.3 Roles and Responsibilities 32
2.4 Other Public Bodies 41
3. KEEPING ABORIGINAL CHILDREN SAFE AND WELL 49
3.1 Our History 49
3.2 Aboriginal People And The Child Welfare System 50
3.3 Strong Families And Communities Keep Children Safe 52
3.4 Hearing Aboriginal Perspectives 54
3.5 Transferring Governance To Aboriginal Authorities 55
3.6 Delegating Powers To Aboriginal Agencies 56
3.7 An Aboriginal Face for the New Representative for Children and Youth 61
4. MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT 67
4.1 Decentralization 67
4.2 Quality Assurance and Accountability 75
4.3 Ministry Review of Child Injuries and Deaths 87
4.4 Modern Approaches to Child Protection 98
5. COMMUNICATION AND COORDINATION 105
5.1 Coordination 105
5.2 Information Sharing 109
6. FAILED TRANSFER OF FILES AND FUNCTION 123
6.1 Transfer of the Child Death Review Function 123
6.2 Transfer of the Death Review Files to the Coroner 129
7. THE PATH FROM HERE 139
7.1 Dedicated Transition Team and Staff 139
7.2 Representative for Children and Youth 140
7.3 The Coroner 140
7.4 The Ministry of Children and Family Development 140
7.5 Budget, Staffing and Resource Implications 141
APPENDIX A. – RECOMMENDATIONS 147
A.1 Summary of Recommendations 147
APPENDIX B – INTERVIEWEES AND PUBLIC SUBMISSIONS 156
B.1 List of Interview Participants 156
B.2 List of Public Submissions 158
APPENDIX C. – MINISTERIAL CORRESPONDENCE 164
C.1 Correspondence: Dec 14, 2005 - page 1, 2 165
C.2 Correspondence: Jan 6, 2006 - page 1, 2, 3 167
C.3 Correspondence: Jan 31, 2006 - page 1, 2 170
C.4 Correspondence: Feb 10, 2006 - page 1 172

1

First Words

Honourable Ted Hughes
OC, QC, LL.D. (Hon.)

FIRST WORDS

- ☐ What Led To This Review
- ☐ My Review
- ☐ How I Conducted This Review
- ☐ Where We Are Today
- ☐ This Report

1. First Words

I was told when I accepted this assignment that it would be a straightforward task, easily accomplished in the space of a few weeks. That turned out to be hugely mistaken. What I have discovered in the past four and a half months is that child welfare is a many-faceted system, complex in each of its parts. And I have learned from the many knowledgeable people who agreed to be interviewed and the nearly 300 more who wrote and phoned, that there is no great consensus awaiting my discovery.

I have done what I could to live up to my mandate but am mindful that there is much more to say. This report may not be as comprehensive as some would have wished, but in the time allotted and within my terms of reference I have tried to address the most pressing issues and to suggest ways of moving forward.

The strongest impression I have gleaned from this inquiry is one of a child welfare system that has been buffeted by an unmanageable degree of change. There has been a revolving door in senior leadership positions; emphasis in practice has shifted between child protection and family support; functions have been shifted out to the regions and then pulled back to centre; new dispute resolution processes have been introduced. And much of this has gone on against a backdrop of significant funding cuts, even though it is commonly understood that organizational change costs money.

To illustrate, within the Ministry for Children and Family Development, between mid-2002 to mid-2003:

- New programs, intended to keep more children at home with their families, were introduced amidst budget cuts to the services that support families and youth in crisis; social workers received no training to help them implement these new programs.
- Five new regional Directors of child welfare were appointed where historically there had been one Provincial Director.
- The Ministry was at work planning for transfer of service delivery and support for children and adults with developmental disabilities to a new Community Living authority, and a sixth Director of child welfare.
- Governance planning absorbed Ministry energy as 11 regions were collapsed into five and work began on moving to regional authority boards.

- A joint Aboriginal management committee began planning for eventual establishment of five Aboriginal authorities.
- The Ministry met stringent budget reduction targets through an almost 12% cut to services for children and families, and a 55% reduction (since 2001/02) in executive and support services, including quality assurance.
- Case review and audit functions were transferred to the regions, with insufficient staff left at head office to ensure that they were being carried out: in fact, practice audits were suspended during this time.

Each of these changes, taken alone, posed challenges to the organization. Taken together they created a climate of instability and confusion that could only detract from the Ministry's work on behalf of children. The need for equilibrium and stability is a central theme of this report.

Any organization has a finite capacity for managing change, particularly in a climate of budget restraint, and this Ministry has been stretched far beyond its limits.

In the 10 years since 1995, the Ministry has been led by no fewer than nine ministers, eight deputy ministers, and seven directors with lead responsibility in child protection. This turnover has taken a toll in terms of staff morale and the Ministry's ability to set directions, frame goals and make progress. The revolving door has got to stop.

At this time, the positions of Deputy Minister for Children and Family Development, Associate Deputy Minister, and the Provincial Director of child welfare all are being filled by acting appointments. Every effort should be made to recruit the most competent candidates as soon as possible and once hired, and barring serious and unforeseen circumstances, the new appointees should be left in office for a minimum of four years. Five would be better.

Child welfare practice itself has been subject to cyclical patterns. Looking at statistics over the years on children being taken from their families and into care, we see the numbers decline for several years and then begin to climb, sometimes quite suddenly.

For example, there was a spike in the number of apprehensions during and after the Gove Inquiry in 1995 when child safety concerns were brought to the fore. More recently, the numbers have gone down as social workers are asked to use alternative arrangements where possible, rather than bringing children into care.

I hope that some of the recommendations in this report can help to achieve a balance so that the pendulum can return to equilibrium.

What will be required, more than anything, is a spirit of cooperation and collaboration among the leadership in our child welfare system, not only in the Ministry of Children and Family Development, but in other ministries and government agencies as well.

Front and centre among those whose cooperation I invite, are the elected Members of the Legislative Assembly. I am recommending a key role for them in leading the way towards changes I see as essential to the safety and well-being of our children and youth—our leaders of tomorrow.

1.1 WHAT LED TO THIS REVIEW?

In an ideal world, all children would be cared for in their homes, with nurturing adults to keep them safe and care for them. That is the reality for most children in British Columbia, but some children have needs that surpass a family's ability to cope; some parents suffer from the effects of unrelenting poverty, substance abuse, or other afflictions; some families are unwilling to care for their children; and sometimes children are left with no family at all to stand between them and the world.

Government has long played a role in protecting children who are at risk for any reason, but has always struggled to find the right balance between respecting families' autonomy and privacy on the one hand, and intervening to protect vulnerable children on the other.

From the appointment of BC's first Superintendent of Neglected Children in 1919, the scope and delivery of child welfare services have evolved to meet changing conditions and to reflect a general growing awareness of child abuse and neglect and of the rights of children and families.

A new chapter in British Columbia's child protection history began in 1994 when Judge Thomas Gove was appointed to head an inquiry into the death of Matthew Vaudreuil, a little boy who was killed by his mother while he was a client of the province's child protection system. Over the next 18 months the Gove Inquiry looked at the policies and practices of the child protection system and other services provided to children and youth by government ministries and agencies.

A perhaps unintended result of the inquiry itself was a shift in child protection practice towards removing more children from their homes rather than offering support so that families could stay together: feeling attacked by the adverse publicity surrounding the inquiry, social workers were afraid of leaving children in situations where there was any possibility that they might come to harm.

In the summer of 1995, before Judge Gove had issued his report, the government responded to public consultations conducted in the early 1990s about BC's child protection system and appointed the province's first Child, Youth and Family Advocate.

Once the Gove report was received, government was quick to adopt it and appoint a Transition Commissioner to study its recommendations and develop an implementation plan.

Fundamental changes resulted, including:

- creation of a new Ministry of Children and Family Development, which was to integrate child, youth and family programs and services from the former ministries of Social Services, Education, Health, Women's Equality, and Attorney General, under one umbrella ministry; and
- creation of the Children's Commission to review child deaths and oversee the activities of the new ministry.

The Commission undertook the task of reviewing, in one way or another, every child death in the province[1] and making recommendations that were usually aimed at the Ministry of Children and Family Development. It was also charged with reviewing the plan of care for every child in care.

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[1] The Gove Inquiry had recommended only that reviews be done of deaths of those children who died while in care or who had received Ministry services within the preceding 12 months.

Meanwhile, the Child and Youth Advocate was providing advocacy services to children and families who were having difficulty dealing with the Ministry.

The new government's Core Services Review in the summer of 2001 looked at the range of agencies involved in the child welfare system including the Children's Commission, the Child and Youth Advocate, the Coroners Service, the Ombudsman, and the Public Guardian and Trustee. The Review concluded, and government agreed, that there were overlaps and duplication of services. The plan was that the Coroner would assume a child death review function that it had not had before, but which would be more limited than that carried out by the Children's Commission; the Ombudsman would continue to monitor fairness issues; and a new Child and Youth Officer, reporting to the Attorney General, would replace the two former children's agencies as the external oversight body for the child welfare system.

During this period, budgets were being cut across government and the Ministry's child protection services were significantly affected. About the same time, the Ministry was engrossed in transferring responsibility for quality assurance, audit, and practice reviews (including child deaths and critical injuries) to the five regions; significant reorganization was undertaken in anticipation of regional governance; the Community Living Authority, an independent body responsible for services and support to children and adults with developmental disabilities, was created; and major program shifts (referred to as "service transformation") which focused on options to in-care placements, were rolled out to the regions with little or no training, planning, consultation, or follow up.

In early 2004, a group of people in the child protection system felt unable to communicate with the government about the impact these budget cuts were having on children. They turned to Dulcie McCallum (former Ombudsman), Joyce Preston (former Advocate for Children, Youth and Families), and Cindy Morton (former Children's Commissioner) and asked them to use their influence to bring these concerns to the attention of the Premier.

In June, 2004, these individuals wrote to the Premier, pointing out the absence of an independent voice for children and youth who have concerns about the care or services being offered or denied to them. They also noted the lack of public accountability in the Ministry, with no vehicle for informing British Columbians about the resolution of difficult cases, or about the overall performance of the child protection system.

After receiving no response, they released their letter publicly in March, 2005. The media and the Opposition seized on the issue and Premier Campbell committed to meeting with the group.

(There was some confusion as to whether the Premier himself had received the letter.) That story made headlines for a few days and then the deaths of two Aboriginal children who had been receiving services from the Ministry became associated in the public's mind with the issues raised in the letter.

In September, Joyce Preston and Cindy Morton met with the Premier and Minister Stan Hagen and suggested that these most recent deaths illustrated the need for a single office that could conduct a comprehensive review in such cases.

The Ministry came under intense criticism after it released its internal review of the death in Port Alberni of a Nuu-chah-nulth child. Media reports followed about other children who had died in suspicious circumstances: the Ministry's internal reviews had not yet been released, nor had there been a review by the Coroner's Service such as would have been done by the Children's Commission. (See Chapter 2 for a description of this process.) When it became clear that the second-stage reviews that the Children's Commission would have done, did not take place on hundreds of files due to the transition, the government's decision to transfer the death review function to the Coroner's Service came under fire.

These concerns ultimately led the Minister of Children and Family Development to ask me to undertake this review.

1.2 MY REVIEW

My Terms of Reference

The Minister of Children and Family Development appointed me to do an independent review of the child protection system in British Columbia and to report to the Minister and to the public.

I was asked to examine and make recommendations to improve:

- the system for reviewing child deaths, including how these reviews are addressed within the Ministry,
- advocacy for children and youth, and

- the monitoring of government's performance in protecting and providing services for children and youth.

As part of this examination, I was asked to consider any related matters that I see fit but in particular the roles and responsibilities of:

- the Ministry of Children and Family Development,
- the Child and Youth Officer,
- the Chief Coroner,
- the Ombudsman,
- the Public Guardian and Trustee, and
- any other agencies that may be involved.

Further, I was asked to examine and make recommendations to improve the public reporting of:

- child death reviews to ensure a balance between the need for public accountability, and the privacy interests of families and others; and
- government's performance in protecting and providing services for children and youth in British Columbia.

In a letter to me dated December 14, 2005, the Solicitor General expanded my mandate. He asked that I review the failed process by which responsibility for child death reviews had been transferred from the Children's Commission to the BC Coroners Service, and make recommendations to avoid such failures in the future.

I should clarify that the terms of my review do not include examining the review of any individual child's death, nor does it include a comprehensive examination of child welfare services and programs.

Initially, my report was to be delivered in two parts, the final one to be delivered by April 30. By agreement with government, that arrangement was changed and I am delivering one report today, April 7, 2006.

Guiding Principles

In addressing the questions that have been put before me, I am guided by the principles set out in the *Child, Family and Community Service Act*—the statute that governs our child protection system. It confirms that the safety and well-being of children come first, and will be protected according to these principles:

- Children have a right to be protected and kept safe;
- Families are the best environment for raising a child and parents have the primary responsibility for protecting their children;
- If a family needs support services so that it can provide a safe and nurturing environment for a child, those services should be provided;
- Children's views should be considered when decisions about them are made;
- Even when a child needs protection, the child's attachment to extended family should be preserved if possible;
- Aboriginal children's cultural identity should be preserved; and
- Children need decisions about their upbringing to be made and implemented without delay.

I am also mindful that every child in care has rights guaranteed by section 70 of the *Child, Family and Community Service Act*, including rights to certain standards of care; to be consulted and to express their views, according to their abilities, about significant decisions affecting them; to be informed about their rights; and to be helped to contact the Child and Youth Officer or the Ombudsman.

1.3 HOW I CONDUCTED THIS REVIEW

On November 2, 2005 the Minister of Children and Family Development announced that I would chair a six-member panel to assess the thoroughness and openness of government's approach to meeting the needs of vulnerable children and investigating child deaths. Judge Thomas Gove would serve as a resource to the panel.

It soon became clear that the panel would be unworkable. First, the time frame for this report was so short that it would be impossible to schedule the necessary time together to complete the work. Second, as public attention became focused on the management of child death reviews it seemed unwise to include on the panel the people leading the agencies whose roles would be scrutinized. So, on November 18, it was announced that I would conduct the review and would seek the expert advice of previously announced panel members, Jane Morley, BC's Child and Youth Officer; Grand Chief Ed John, BC's former Minister of Children and Family Development; Joyce Preston, the former Child and Youth Advocate; and Terry Smith, BC's Chief Coroner. Maureen Nicholls, a former deputy minister who was to have sat as a panel member agreed to assume the role of executive director of the project.

Staff

Our office opened on November 25, 2005. We have been assisted throughout by a clerical staff of two, Linda Falconer and Kaisha Goodacre, who have diligently performed all tasks requested of them.

I must record the outstanding contribution to the work of the Review by four dedicated professionals who have been the backbone of the structure that has enabled the overwhelming task given to me to be accomplished within our tight timeframe.

Maureen Nicholls, mentioned above, brought to the office her vast experience within the senior ranks of government service and also her experience as a member of the legal profession. As Executive Director she gave constant and focused leadership day in and day out and to her I offer my sincere appreciation for the excellence of her endeavours.

It soon became apparent that I required the presence in the office of someone with intimate knowledge of the operations of the Ministry of Children and Family Development, with emphasis on the delivery to those in need of child welfare services by professional social workers. I asked that Clara Robbins be seconded to serve as Director of Research and Analysis for this review. She has fulfilled the role required of her with dedication and commitment. I am grateful for her assistance which has exceeded my expectations at every turn.

Kim Thorau, a seasoned public policy consultant, has brought her extensive knowledge of government and her organizational skills to assisting my office in the challenge of pulling together this report under very tight time constraints. Her wit, wisdom and energy are most sincerely appreciated.

Kathleen Keating is an associate and colleague of long standing with whom I have worked over the years on many public assignments. She is a professional in every sense of the word, in the rare combination of law and journalism. The advice and assistance she has given me in the production of this report, with respect to both content and form, has been invaluable. She has worked diligently to put the thoughts and message I want to convey in organized and easy to read format. My sincere thanks to her.

Those people who had initially been named as panel members, and Judge Gove and 70 others with special expertise gave generously of their time, often on weekends, and shared with me the benefits of their wisdom, experience and insight.[2]

Public Consultation

I also wanted to hear from groups and organizations involved with the child welfare system, from individuals who had used the system, and from any member of the public who might have information or opinions to share. During December, advertisements were run in every daily and weekly paper in BC, inviting submissions. The advertisement appeared more than 300 times, including Punjabi and Chinese translations, and 240 individuals and organizations responded. In January an information bulletin was faxed and emailed to about 130 groups, offering an opportunity to make telephone submissions and a further 50 responded by telephone.

To encourage the utmost candour, I promised everyone who was interviewed or who contributed in writing or by telephone that I would not attribute particular comments to anyone.

Research

I soon realized that I had a great deal to learn in a short time, so researchers were contracted to provide me with reports on the child death review process; child and youth advocacy; performance outcome measurements, monitoring and public reporting; and budget matters, staffing and training. These reports may be found on the BC Children and Youth Review website at http://www.childyouthreview.ca.

File Review

Finally, I needed to understand what had happened to the child death review files that were held by the Children's Commission at the time that office was disbanded and responsibility for these reviews, in some form, was handed to BC's Chief Coroner. To do that, we gained access to all of those files to confirm their number, location and their review status. We also worked closely with the Coroner's office to understand what current process is underway for further review of those files, and the status of that process. These files are discussed in Chapter 6.

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[2] A list of those who were interviewed is at Appendix B.

1.4 WHERE WE ARE TODAY

Following is a brief synopsis of the current state of affairs with respect to the issues I have been asked to consider.

The Ministry of Children and Family Development

In February, 2006, both the Deputy Minister and the Provincial Director of Child Welfare (who also held the post of Assistant Deputy Minister) left the Ministry. Individuals have been appointed to these positions on an acting basis.

Coroner's Inquest

On February 17, 2006, a coroner's jury completed a 10-day inquest into the homicide of a 19-month-old Aboriginal child in Port Alberni. The jury made 19 recommendations, some of which were directed at training for social workers; better reporting of suspected abuse; tighter controls around "kith-and-kin" placements; and better communications among police, social workers and medical professionals. The jury also recommended reinstatement of the Children's Commission.

New Provincial Budget

On February 22, 2006, British Columbia's Finance Minister tabled the provincial government's budget proposal for 2006/07, which she described as "a budget designed to improve services for children." It includes an increase for the Ministry of Children and Family Development of $278 Million in new funding over the next three years. The Ministry has indicated that this new funding will support its priorities of prevention and support services and in particular for:

- children and youth at risk
- children and youth with special needs
- child and youth mental health, and
- Aboriginal governance.

Of this new funding, $100 Million is to be invested in child and family services, and to respond to this and the other external reviews undertaken in recent months.

The spending will be allocated over three years, with $20 Million in 2006/07; $30 Million in 2007/08; and $50 Million in 2008/09. In addition, up to 400 new staff positions ("FTEs" or "Full Time Equivalents") will be added by the 2008/09 fiscal year. These new positions will be allocated among service areas on the basis of demonstrated need and will support service delivery and quality assurance.

On February 24, 2006, British Columbia's Attorney General released the report he had requested from the Child and Youth Officer respecting the Director's case review that the Ministry had conducted into the death of the Aboriginal child mentioned above.

The report examined the delays in completing the Ministry's review and made recommendations for improving the process. I have carefully considered the report of the Child and Youth Officer in the context of developing my own recommendations.

1.5 THIS REPORT

Throughout this report I most often use the word "children" to include all children and young people under the age of 19. I recognize that "children" fails to convey the very different needs and life circumstances of teenagers, especially those approaching young adulthood, but I have taken those perspectives fully into account in my review.

In Chapter 2 I propose a new, independent body to oversee the child welfare system: the Representative for Children and Youth. The Representative will be appointed as an Officer of the Legislative Assembly and will report to a Standing Committee of the Legislature that will be established to address issues of children and youth.

The Representative will build on the strengths of the current Child and Youth Officer and the earlier Children's Commission and Child and Youth Advocate and will embody the most valuable aspects of each of them. In particular, it will push for improvements to the child welfare system; it will support individual children and families who need help resolving conflicts with the Ministry; and it will monitor and report on government's services to children and families, and on the Ministry's responses to child deaths and critical injuries.

I offer a new approach to the issue of child death reviews. I recognize that this may be the most contentious single item I have been asked to address and I should say a word here about my approach.

Amidst the current controversy and in the aftermath of the tragic death of a child, what is sometimes lost sight of is that the death rate among children in British Columbia is declining and has been for years. Deaths of children in care are also declining, though less dramatically. These downward trends may result from improvements in the health status of the population generally; from better skills and resources for treating ill, injured and troubled children; or from a reduction in risky behaviours that claim young lives every year on our roads and in our communities. Whatever the causes, recent trends are positive.

Still, it would be naïve to believe that children will not continue to be seriously injured or die needlessly. Every child's death from abuse or neglect diminishes us all, and every child's unexpected death needs to be examined carefully. In addition to any other investigations into a child's death by police, a coroner or in legal proceedings, we have the right to expect that every suspicious or unexpected death of a child in the child welfare system be reviewed in a timely, thoughtful and impartial manner, with a view to learning lessons that can guide protection, parenting and care giving practice in the future, so that similar tragedies can be avoided.

At the same time I recognize that there is a limit to what can be learned from the review of individual children's deaths. There are many more lessons to be taken from children's lives and from their experiences with the Ministry, with their families, with the medical system, their schools and communities. A public health perspective can help us to find and use the information that make a difference to children's lives and, we hope, further reduce the number of children who needlessly die.

In this context, I set out the roles and responsibilities of other public bodies that have contributions to make to the public oversight of the child welfare system: the Public Guardian and Trustee, the Ombudsman, the Provincial Health Officer, the BC Injury Research and Prevention Unit, and the Coroner's Service.

Advocacy for children, youth and families in the child welfare system will be an important function for the new Representative for Children and Youth. Child and family advocacy has suffered in recent years. The Child, Youth and Family Advocate was eliminated, as was the Child and Youth Mental Health Advocate and the Family Advocate program in the Ministry of Attorney General, and legal aid funding for family matters was cut. Some rationalizing of government-supported advocacy programs may have been appropriate but the pendulum has swung too far for the good of the most vulnerable in our society—our children and youth. Among the individuals and groups I heard from there is broad support for the provision of advocacy services for individuals as well as systemic advocacy, which I define as working towards positive change in policies, practice and service delivery in the child welfare system.

In Chapter 3 I consider the unique situation of Aboriginal children and families in our child welfare system. I am disheartened by the rate of suicide among young Aboriginal people and by the ever-increasing numbers of Aboriginal children being taken into care, especially when that means removal not only from their families but from their communities as well. There may be no quick solutions, but immediate measures can be taken to begin consulting in a meaningful way with Aboriginal communities so that Ministry policy and procedures can better meet their needs; to attract and keep Aboriginal people in leadership and frontline child welfare positions; and to better support the 23 Aboriginal agencies now providing child welfare services to their communities.

But the child welfare system alone cannot address the poverty, substance abuse, limited economic opportunities, substandard housing and other challenges facing Aboriginal families. The roots of these problems run deep in our history and they will not be overcome without the best efforts and full cooperation of Aboriginal leaders and federal and provincial governments. We have an opportunity now to build on the commitments made in the Kelowna Accord to close the socio-economic gaps between First Nations people and other British Columbians.

The strategic vision that this Government has articulated for British Columbia includes building the best support system in Canada for children at risk; making BC the best educated, most literate jurisdiction on the continent; and leading the way in North America in healthy living and physical fitness. These goals will not be met until they are met for British Columbia's Aboriginal population and they cannot be achieved without the full participation and engagement of Aboriginal leaders, families and communities.

Chapter 4 addresses the Ministry of Children and Family Development, and especially the impacts of decentralization both to geographic regions and eventually to Aboriginal authorities.

The move to decentralize services and authorities to the regions, and eventually to Aboriginal governance authorities, poses many challenges for the Ministry and I address these here. I support the move to decentralization, but only if important guidelines are respected.

Public accountability assumes even greater importance in a decentralized system and here I address the government's responsibility to be accountable to the public for its performance in protecting and serving children and youth. Accountability requires measuring performance and then reporting on those measures in a meaningful way. I propose a child-centred approach, which means looking not at what was done, but what was the outcome for the child.

Also in this chapter I discuss changes in Ministry policies and procedures that have resulted in fewer children being taken into care and greater use of other arrangements such as kith-and-kin and youth agreements. I support those practices that help to maintain children's ties to their families, or that allow young people to live independently, but these arrangements need to be supported with resources and services if children and young people are to thrive.

In Chapter 5 I discuss basic principles of communication and information sharing that are essential if all elements of government's child-serving system are to work together for the benefit of children and their families. I also deal with some of the impediments to information sharing, and how to overcome them.

In Chapter 6 I discuss what happened in the transfer of the child death review function to the Coroners Service. I tell what discovered about the transfer of 955 child death review files from the former Children's Commission to the Office of the Chief Coroner. All of these files have been inspected for the purposes of this review and I tell what has been learned about them and what has happened to the files.

Finally I outline a plan for implementing the recommendations I have made, including reference to budget, training and staffing considerations. I hope that with proper planning, resources and accountabilities in place, the implementation of the recommendations I make here can be accomplished smoothly and effectively, avoiding the pitfalls of recent experience.

In the best interests of our province's most precious assets—children, youth and families—I call upon the Government to move towards substantial compliance with what is proposed in this document. My terms of reference were quite specific, but I believe that a blueprint will be found here to allow for full repair of a system that has in recent times been battered on stormy seas.

I also make a call upon the Official Opposition in the Legislature. As its members fulfill the responsibilities that rest with them, let the same interests be their guide as they provide constructive criticism and such support for the blueprint as they deem reasonable.

2

A New Plan for External Oversight

A NEW PLAN FOR EXTERNAL OVERSIGHT

☐ The Evolution of Independent Bodies
☐ New Representative for Children and Youth
☐ Officer of the Legislature
☐ A New Standing Committee
☐ Roles of the Representative
☐ Respect and Trust

2. A New Plan for External Oversight

During the past 10 years, British Columbia has tried three approaches to making sure that vulnerable children, youth, and their families receive the child welfare services they need, that they are treated fairly by the child welfare system, and that particular attention is paid to child deaths and critical injuries.

The Advocate for Children, Family and Youth; the Children's Commission; and the Office for Children and Youth each have had their own successes and though none were able to fully meet the challenges set before them, each performed valuable services that are still needed today.

I am proposing a new body—a Representative for Children and Youth—that will build on the strengths of its predecessors and on the lessons learned from their experience. It will resemble in significant respects the current Office for Children and Youth, but it will have the independent status that was held by the Advocate, and will perform some of the functions that were carried out by the Commission. Further, its reporting process will be designed to help depoliticize the debate around child welfare issues.

I recognize that this new body represents another change in a system that I have said requires stability. However, I believe that it is not a departure but rather a progression in the direction that the child welfare system has already embarked upon.

The current Office for Children and Youth has performed its duties independently, but if public confidence in the child welfare system is to be restored, the independent body that speaks for children and youth must have a status that puts that independence beyond question. That is why I am recommending that the new Representative for Children and Youth be an independent Officer of the Legislature, with the same standing as the Ombudsman and the Auditor General.

To encourage our legislators, who have ultimate responsibility for our child welfare system, to engage in constructive discussion of these important issues, the Representative and the two Deputy Representatives that I recommend later in this report will be required to appear annually before an all-party committee of the Legislature.

This will be an opportunity for the Representative to make a full report to the members and answer their questions. That committee will table the Representative's annual report before the House.

2.1 A LEARNING PROCESS

The evolution of independent bodies for children and youth in British Columbia reflects our growing awareness of the rights of children and youth, and of the need for public accountability by government. Each was an attempt by government to meet the need for public accountability without intruding on the mandate of the Ministry and without overburdening the capacity of the independent body.

The Advocate for Children, Youth and Families

In the early 1990's the government had undertaken to improve the province's child protection legislation and sought public input. A message heard loud and clear was that children, youth, and families need someone to help them when they run up against problems within the system. The government responded with the *Child, Youth and Family Advocacy Act* and the appointment, in the spring of 1995, of a Child, Youth and Family Advocate. The Advocate was an independent officer of the Legislature, mandated "to ensure that the rights and interests of children, youth and their families relating to designated services are protected and advanced and that their views are heard and considered." This was the first position of its kind in British Columbia.

The Advocate played a useful role on behalf of young people who needed help in making their voices heard within the system. The Advocate also worked with community groups to build capacity for advocacy in the regions. Staff at the Advocate's office had an excellent reputation for advocating effectively on behalf of individuals, and were appreciated by their clients and by social workers as well. The Advocate also played a systemic advocacy role and was often a vocal critic of government. The result sometimes was an attitude of defensiveness on the part of the Ministry.

The Children's Commission

Soon after the Advocate's appointment came the report of the Gove Inquiry with its proposals for improving the child protection system. One of its key recommendations was the creation of a Children's Commission to review deaths and serious injuries of children who were in care or receiving child welfare services; investigate complaints and monitor the Ministry's complaint process; and review annually all continuing care orders.

If the position of Advocate had not recently been created, with its particular focus and set of skills, I expect that there would have been a single new body, with a comprehensive mandate including individual and systemic advocacy, monitoring functions, and review of deaths and injuries. However, with the Advocate already in place, a Children's Commission was established and given a mandate in which advocacy played a limited role.

The Commission's role in death reviews, however, expanded beyond the Gove recommendation and is discussed later in this chapter.

Child Death Review Procedure

The Commission adopted a three-tiered approach to its child death reviews.

1. **Data collection:** The Commission developed its own database that it used to track information on every child death in the province. From the Ministry's database, it could determine whether the child or the child's parents appeared anywhere in the Ministry's records.
2. **Second level investigation:** Unless the child had died from natural causes, one of the Commission's investigators would investigate further. If others, such as police or the Coroner, were already looking at the relevant issues, the Commission would wait for their reports. At that stage the Commission would decide whether to do a full investigation.
3. **Full Investigation:** This could be prompted by the circumstances of the death, or by a parent's request for more answers, or by special concerns the Commissioner might have. An investigator would produce a report that would go before a multidisciplinary team of experts in child care; policing; social work; children's medical services; public health and suicide prevention; as well as representatives from Aboriginal communities and the Coroner's office. The team met every two months to review about 20 files and develop recommendations. They would also discuss emerging patterns that might inform future Commission reports.

The Commission's database eventually captured information on the deaths of 2,563 children (including deaths that predated the Commission). It did full investigations of 769 deaths, including:

- all deaths, by any cause, of any child in care;
- all child and youth suicides;
- all deaths of children and youth in questionable circumstances;
- all cases that raised questions about coordination amongst agencies; and
- most accidental deaths of children and youth.

The Commission's reviews focused not only on the circumstances of the death, but on what had happened in the child's life and the risks the child had faced, to see what could be learned about service delivery and about how those risks could be minimized for other children. Sometimes the review expanded to include the lives of the child's parents, especially if the parents themselves had been in care in the past.

Some files were closed within six months of a death, but the majority took two to three years to complete.

Besides its annual reports, The Children's Commission was required by its statute to report to the Attorney General its findings and recommendations with respect to child injuries and deaths, and any responses from ministries or agencies. Those would then be made public within 30 days after presentation to the Attorney General.

In its early days, the Commission issued a full report (with names removed) on each file as it was completed. Later it began releasing a number of reports at a time, in summary form, to better protect families' privacy. All deaths, including those that were not the subject of a full investigation, would be included (statistically) in the Commission's annual report, and possibly in special studies.

The Commission's 769 death reviews were the evidentiary basis for the special reports it did. These special reports aimed to raise awareness of a range of issues, from sudden infant death syndrome, to the influence of alcohol on the lives and deaths of children and youth.

When the Commission observed, after reviewing the deaths of a number of young people in car accidents, that fatal accidents often involved more than three young people in a vehicle; the Commission provided that information to ICBC and worked with the insurer in developing its graduated licensing program and public education initiatives.

The death reviews also led to the 897 recommendations made by the Commission, most of which were directed to the Ministry. Some tended to cover the same ground, and some were highly critical, so that an attitude of defensiveness developed in the Ministry, which felt itself bombarded by recommendations and criticism.[3] I have been told that the situation had reached a point where the ability of the Ministry to do its work most effectively was being compromised.

Narrowing the Focus of Reviews

The Commission was seen by some as a pioneer in the field of child death reviews and served as a model for other jurisdictions looking for ways to improve their own child welfare systems. In 1998, BC's Ombudsman[4] reported that the Commission had been "of immediate and significant benefit to children" and "for the first time in our province is able to inform government about detailed factors that have contributed to and caused the deaths of children so that comprehensive steps can be taken to prevent recurrence."

But even among those who felt that it was important in the beginning to investigate a large number of deaths, there seems to have developed general agreement that the number of full investigations could safely be cut back considerably. Some suggested that 20 or 30 a year would be sufficient.

By 2001, the Commission was trying to shift its focus towards an analysis of trends, and the Commissioner and the Advocate were discussing combining their offices.

Then came the core services review of the functions of the Commission, Advocate, Coroner's Service, Public Guardian and Trustee, and the Ministry, which looked for ways to eliminate gaps and overlaps in their services.

The core services review recommended cutting back the scope of the child death review mandate and placing this narrower responsibility exclusively with the Coroners Service.

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[3] In December, 2001 Jane Morley's Report on the Core Services Review of the Children's Commission stated that of the 700 recommendations that had been made at that time, 300 had been implemented fully, 300 partially, and 100 had not been implemented at all.

[4] Office of the Ombudsman: *Getting There: A Review of the Implementation of the Report of the Gove Inquiry into Child Protection,* March 1998

The Coroner—if given sufficient resources—was seen to be "in a position to develop a more focused, timely process, bringing in expertise from different fields and resulting in recommendations that are implemented."[5]

I agree that in the beginning it may have been productive to conduct as many investigations as the Commission did. It gained an understanding of certain risk factors, and by recording information about all deaths, the Commission created a useful database that is still available. But over time, the investigation of 120 or so deaths annually and production of hundreds of recommendations proved less useful as a tool for prevention. By the end of its life, the Commission's recommendations carried less weight than they might have, had its death review function been more focused.

The Office for Children and Youth

By the time the government undertook its core services review in 2001, it was obvious to many that there were significant overlaps among the services offered by a number of public bodies, and some confusion in the public's mind about their roles. The core services review found that having both the Advocate's office and the Commission was "neither efficient nor effective" but that one children's officer could be helpful to government in carrying out its responsibilities to vulnerable children and youth.

The result was the replacement of the Children's Commissioner and the Child and Youth Advocate with the Office for Children and Youth in 2002. The plan was that:

- The individual advocacy that had been central to the Advocate's work, and the Commission's complaints handling process, would be less important because the Ministry would do a better job of handling complaints internally; if people weren't satisfied with the Ministry's processes, they would still have recourse to the Ombudsman.
- Most of the Commission's monitoring practices would be unnecessary because the Ministry would monitor and report on its own performance more effectively than in the past.
- There would be fewer reviews of individual child deaths and a greater emphasis on analysis of trends: this role would go to the Coroners Service.

The Office for Children and Youth was placed within the Ministry of Attorney General to give it a measure of independence from the Ministry of Children and Family Development, which it was intended to oversee. Its focus is government-funded services for children and youth, including family support, child protection, adoption, guardianship, child and youth mental health, youth justice, and several others. The Office describes itself as a champion for children and youth; a critic providing both negative and positive analysis and review; and a catalyst for positive change.

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[5] *Jane Morley, "Death and Life Issues for B.C.'s Children," December, 2005*

I support the direction of this office but to date there has been no clear understanding by the public of its role and despite its efforts, public confidence in the child welfare system remains at low ebb.

The Coroners Service

All deaths, whether child or adult, that meet the criteria set out in s.9 of the *Coroners Act* are required to be reported to the Coroner. Generally speaking, these are "unexpected or unexplained" deaths. The extent of the Coroner's investigation depends on the circumstances. Most result in a report called a "judgment of inquiry," usually a short report describing the immediate circumstances and cause of the death. A public inquest is rare but will be held if necessary to obtain evidence, or to bring attention to a recurring situation, or to satisfy the public's need to understand a particular situation, such as a high profile death of a child. A coroner's investigation does not normally delve into the deceased person's background.

When the Children's Commission was closed, the Coroners Service was given responsibility for reviewing child deaths. This review function is over and above its investigation role, but it is narrower in scope than the review function as performed by the Children's Commission. I discuss this service and the role that it will continue to play, later in this chapter.

Other Public Oversight Bodies

These were not the first or the only public bodies in British Columbia, external to the Ministry, to carry responsibilities with respect to the child welfare system, and child injuries and deaths. Each of these new institutions has functioned within an existing network of public bodies that fulfilled related duties, and still do:

- The Office of the Ombudsman investigates complaints about services provided by a public body, including the Ministry. The Ombudsman does not act as an advocate but can give advice about how to pursue a dispute with the Ministry.
- The Public Guardian and Trustee protects the legal and financial interests of a child who is in care, and starts or defends legal actions on the child's behalf, when required.
- The Provincial Health Officer reports on the health of British Columbians, including a *Review of Infant Mortality in British Columbia: Opportunities for Prevention* (2003); and the Office's 2001 annual report, titled *The Health and Well-being of Aboriginal People in British Columbia*, which provided an update on British Columbia's progress toward the goal of improved health for Aboriginal people. Its 2001 report titled *Children and Youth in Care: An Epidemiological Review of Mortality, British Columbia*, April 1974 to March 2000 is soon to be updated with a report that will also include data on the educational and hospital experiences of children in care.[6]

I discuss continuing roles for these agencies later in this chapter.

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[6] These reports are available on the Provincial Health Officer's website: http://www.healthservices.gov.bc.ca/pho/index.html

2.2 A NEW REPRESENTATIVE FOR CHILDREN AND YOUTH

An Officer of the Legislature

I am recommending that a Representative for Children and Youth be established as soon as possible and that the position be an officer of the Legislature. The appointment process should be that used for other officers of the Legislature such as the Ombudsman, the Auditor General, and the Information and Privacy Commissioner, which is by recommendation of the Legislative Assembly upon unanimous recommendation by a special committee of the Legislature.

I am aware of the argument that the requirement of an appointment that satisfies both political parties can diminish the possibility of securing the best possible candidate, but I believe it is worth doing. Much of course will depend on the character and personality of the person chosen. That person will need to approach the task in a spirit of cooperation and collaboration with the many components of the child welfare system, and a deep commitment to and understanding of children's needs.

The appointment should be for a term of five years, with the possibility of reappointment to a maximum of ten years.

The Representative will have the authority to advocate for individual children and families; advocate for system change; monitor the child welfare system; and review child injuries and deaths.

A New Standing Committee

I am also recommending that the Legislature strike a new standing committee on Children and Youth, and that the Representative and Deputy Representatives report to this committee at least annually. I believe that the establishment of this standing committee will help Members of the Legislative Assembly to understand that their relationship with the Representative should be a collaborative one. It should also help to develop a greater awareness and understanding among legislators and the public, of the child welfare system in our province. It is my fervent hope that it will encourage Government and the Opposition to work together to address some of the very real challenges facing the child welfare system now and in the near future.

Roles of the Representative

I want to share my views on what I believe is the appropriate role of this Representative. Briefly, the role has two dimensions: one focused on contact with individual children, youth and families, and the other addresses the system more generally.

The Representative will support, assist, inform, and advise children, youth and families who may need help in manoeuvring through the child welfare system, or who may have a complaint about services and programs.

The second part of the office's mandate will be to monitor, review, audit and investigate the performance and accountability of the child welfare system. In this second aspect of its role, the Representative will focus not on the day-to-day operations of the child welfare system (such as reviewing all plans of care, as was done by the Children's Commission), but on broader, system-wide issues.

This may not be a permanent aspect of its mandate. As discussed below, it is unusual to have an external body overseeing the functioning of a government ministry. This is essential at this time, to restore public confidence in the child welfare system, but it may not always be necessary. I suggest that this area of responsibility be reviewed in five years time: if conditions have changed substantially by then, the mandate of the office may be revised at that time to include only its advocacy functions.-

Recommendation 1

1

That a Representative for Children and Youth be appointed as an Officer of the Legislature, for a five year term, renewable to a maximum of 10 years.

Reason

The status of an Officer of the Legislature, and a fixed term appointment, will give the public confidence in the office's independence.

Recommendation 2

2

That the Legislature strike a new standing committee on Children and Youth, and that the Representative and Deputy Representatives report to this committee at least annually.

Reason

This all-party committee will contribute to a greater understanding among legislators and the public, of the province's child welfare system and will encourage Government and the Opposition to work together to address the challenges facing the system.

Respect and Trust

An effective oversight body requires two essential elements: the trust of the public, and the respect of the bureaucracy.

The public's trust can only be earned if there is obvious independence. The Representative that I have recommended will demonstrate independence through the method of appointment; the term of appointment; and its independent powers of investigation, consultation and public reporting.

Respect from the bureaucracy will be earned through professionalism and a thorough understanding of the role. Without this respect, recommendations from the oversight body will have little credibility with the bureaucracy, which will have to be relied on for their implementation.

The Representative will have the power to recommend, rather than order, change. The reason is simple: the Representative is not intended to replace or oppose government decision-making. Instead, it is there to assist, encourage and sometimes prod the government to be more aware and responsive to the individual concerns of children, youth and families; and to recommend changes that will address broader problems in the child welfare system.

Stephen Owen, former Ombudsman for British Columbia, in commenting upon the Ombudsman's ability to recommend, not order, change, has written:

> *This inability to force change may be the central strength of the office. It requires that its recommendations be based on a thorough investigation of all facts, scrupulous consideration of all perspectives and vigorous analysis of all issues.*
>
> *This application of reason produces results that are more powerful than could be achieved through coercion. A coercive process may produce reluctant change in a particular instance, but it creates a "loser" who will be unlikely to embrace the change in future. By contrast, change that results from a reasoning process changes a way of thinking and the result endures, to the benefit of future users.*

The application of reason, rather than coercion, does not detract in any way from the Representative's ability to be critical of a government policy or practice (or to be complimentary). But when criticism is supported by thorough investigation, consideration of all perspectives, and thoughtful analysis, it is much more likely to influence positive change.

2.3 ROLES AND RESPONSIBILITIES

Advocating for Children and Youth

I understand, from my consultations, that children, youth and their families do sometimes need help and support in finding their way through the child welfare system and making their views known and understood. Advocacy is a way of reminding everyone involved in a disagreement over child welfare services, that this is about the child.

A primary function of the new Representative for Children and Youth will be promotion and coordination of advocacy services for children and youth in the province. Advocacy in this context means:

- Helping a child or youth to make sure that his or her interests, rights and views are heard and considered in decision making.
- Providing general information and advice on the child welfare and child protection system and on the rights of children, youth and their families within the system.
- Supporting, building and developing advocacy awareness and support systems in communities: the Representative should establish satellite offices in each region to support this work.

- Working with the Ministry to open up its internal procedures so that people who are making decisions that affect children's lives can understand and consider the child's own rights and views. I discuss the Ministry's internal dispute resolution system in Chapter 4.

The Ombudsman continues to have a role to play but does not fill the gap: the Ombudsman's mandate is to review administrative fairness issues, not to help individuals to have their voices heard. The Ombudsman responds to complaints of individuals about practices and services of public bodies, including the Ministry, and resolves some complaints informally through negotiations.

The Ombudsman also may investigate and make recommendations in relation to a broadly defined area of complaints about practices or policies that are contrary to law, unreasonable, unjust, oppressive or improperly discriminatory. The office also plays a role in monitoring and reviewing the Ministry's complaint process.

Advocating for Change

There is also a need for an external body to push for change to the system from time to time. The Representative will have the authority, the expertise and the resources to study the child welfare system from an informed but external perspective and recommend change where needed.

To a large extent, the Representative's expertise will be developed over time as it works through the resolution of individual cases that come to it for individual advocacy services. By analyzing trends in complaints, it will be able to identify underlying causes of recurring problems and offer timely and constructive recommendations for improvement.

I am not recommending that the Representative have any power to impose its views on the Ministry. Its influence will lie in the power of reason, not coercion.

An important by-product of this accumulation of experience could be requests by government institutions or ministries for the Representative to take part in the development of policies or practices that reflect a deeper understanding of the needs and interests of children, youth and their families. Some might be concerned that the Representative's ability to comment impartially on the application of a policy that it has had a hand in developing could be compromised, but I don't share that view. The Representative should be engaged in constantly helping the system improve itself.

Recommendation 3

3

That the Representative for Children and Youth be mandated to support and advise children, youth and families who need help in dealing with the child welfare system; and to advocate for changes to the system itself.

Reason

Vulnerable children and families will always need someone to help them from time to time in their dealings with the child welfare system, and social workers too, often appreciate helpful interventions from the outside, on behalf of their clients.

Monitoring the Child Welfare System

Most government ministries are not subject to formal oversight by an external body and it may be that in the future, there will be no need of an independent office for children. The Ministry's own performance measurement, quality assurance programs, and public reporting may in themselves be sufficient to assure British Columbians that vulnerable children and youth are being protected as they should be.

But at this time, to meet public concerns, an external agency remains necessary as the Ministry continues to enhance its ability to measure, monitor and report on its own performance. The public needs to know that the child welfare system is accountable for what it does and how it does it.

To fulfill this key role, the new Representative for Children and Youth will:

- monitor the Ministry's performance in providing designated services[7] to children, youth and their families;
- monitor the Ministry's performance in establishing and meeting goals for the child protection and welfare system;
- promote the adoption of legislation, policies, standards and practices to protect the rights and interests and wellbeing of children, youth and their families;

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[7] "Designated Services" mean services provided under the *Child, Family and Community Services Act* and the *Adoption Act*, early childhood development and child care services, mental health services for children and youth, addiction services for children and youth, youth justice services, services for youth and young adults during transition to adulthood, and community living support provided under the *Community Living Authority* Act.

- monitor the Ministry's quality assurance activities, including practice audits, case reviews, complaint resolution processes and training and designation of social workers;
- advise government about the effectiveness, responsiveness and relevance of services for children, youth and their families;
- undertake or collaborate in research aimed at improving programs and services to children, youth and their families and the province's child welfare system generally; and
- report regularly to the public on the performance of the child welfare system.

Recommendation 4

4

That the Representative for Children and Youth be mandated to monitor, review, audit and investigate the performance and accountability of the child welfare system, but that this mandate be reviewed in five years and revised as appropriate at that time.

Reason

It may not always be necessary to have an external body overseeing the functioning of the child welfare system, although at this time, the need for public confidence in the system demands it.

Reviewing Child Injuries and Deaths

Is there a need for an external body to review injuries and deaths of children within the child welfare system? That is the question that has most challenged me in the course of my review.

I have learned that many countries have a system for reviewing child deaths and critical injuries[8], particularly where abuse and neglect are factors.

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[8] Critical injuries are those that are life threatening or cause serious or long term impairment to the child's health.

Having said that, the approaches vary widely. And, while there is a large body of research on child abuse and neglect, and on child death rates generally, there is little published material on the case review process and even less on its effectiveness. International studies suggest that it may be a mistake to torque the entire system based on the results of one or two tragic cases that occur in circumstances that might not be repeated. Critical injuries, which occur more often, may be a better indicator of needed change.

Undoubtedly, the review of individual deaths in limited circumstances is important and appropriate and can address the need to instil public confidence in the child welfare system.

However, if child injury and death reviews are to achieve the objectives of improving prevention and addressing the needs of children at risk of harm, I am persuaded that the better approach is through an ongoing program of needs analysis, and evaluation of the results of interventions with children and families. I address these issues in my discussion of quality assurance functions.

I am proposing that the Representative for Children and Youth assume responsibility for reviewing injuries and deaths of children who are in care or receiving Ministry services. It will be a more limited role than that performed by the Children's Commission. The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives.

I have considered whether this role should reside with the Coroners Service and I have decided that it should not. The Coroners Service is a forensic, fact-finding organization. It has important attributes that support its traditional statutory role of investigating unexpected, unanticipated deaths, but it does not have the necessary expertise in the child welfare system.

The Coroner does investigate all unexpected, unanticipated deaths, including those of children in the child welfare system. The Coroner's role is to answer the questions: who died, and how, when, where and by what means? The focus is on the circumstances of the death itself. In contrast, the Representative's investigation will include an examination of the child's life in relation to the child welfare system. The Representative's objective is to determine whether the system may have contributed in any way to the child's death and, if it did, to recommend improvements to service, practice or policy that might prevent future deaths.

Neither the Representative nor the Coroners Service is a fault-finding body. I believe their roles will complement and support one another. With a strong collaborative relationship between them, each will benefit from the others' efforts.

The Representative should have the authority to review child injuries and deaths if the Ministry's services, policies or practices may have contributed in some way to the injury or death and:

a. the injury or death is, or may be, due to neglect or abuse; or

b. the injury or death occurs in unusual or suspicious circumstances; or

c. the injury or death is, or may be, self inflicted, or inflicted by another person.

There may be other extraordinary situations in which the Representative's knowledge and expertise would be beneficial. I recommend that there be legislative authority for the Minister of Children and Family Development or the proposed Standing Committee for Children and Youth to refer any matter to the Representative for investigation and report back.

The Representative should have discretion to determine the kind of review that is appropriate in the circumstances. It may be a matter of collecting and reviewing information on a number of deaths with similar characteristics (for example, youth suicides by hanging), to identify trends or patterns that will inform and educate the child welfare system and the public. It may mean a paper review of an individual injury or death. Or, it may entail a full scale investigation of an individual case, involving interviews of witnesses and compelling evidence.

The Representative should have the powers and protections of a commissioner of inquiry under the *Inquiry Act*.

The Representative should establish a multidisciplinary team to provide advice and guidance both to an individual review, and to assist in the analysis of aggregated injury and death information. The team's core membership should be stable, with particular expertise invited to participate as needed.

In the spirit of collaboration and coordination that I have emphasized throughout this report, I encourage collaboration between the Representative and other bodies that have a role to play in attempting to minimize the risk of harm to children: the Coroners Services, the Provincial Health Officer, the Ombudsman's Office, the Public Guardian and Trustee, and the
Ministry itself.

I propose the Representative provide advice and recommendations to the Minister, the Legislature and the public through annual reports and special reports. This will include reporting on compliance with recommendations, by the Ministry and other public bodies.

In time, I am hopeful that the Ministry's own internal review and public reporting processes will satisfy the public's information needs. That is why I am recommending a review of the injury and death review function of the Representative in five years time.

I have spoken elsewhere about the role of child death and critical injury reviews as important components of an effective quality assurance program.

With respect to the review of child deaths of children who have not been involved with the Ministry, I appreciate that there have been calls from certain quarters for the return of a body such as the Children's Commission to review all child deaths in the province. The focus of the new Representative is on the child welfare system—it has been designed to provide oversight of that system. This is not to say that the death of any child is not profoundly sad, and in unexpected or suspicious circumstances, warranting special attention.

Scrutiny of such deaths is appropriately carried out by the Coroners Service under both its statutory investigative role, and its expanded role in and reviewing child deaths, which I discuss later in this chapter.

Recommendation 5

5

That the Representative be mandated to review certain child deaths and critical injuries. Reviews are to be limited to those children who were in care at the time, or who had been receiving Ministry services during the preceding year. The deaths and injuries to be reviewed are those due to abuse or neglect; or to an accident occurring in unusual or suspicious circumstances; or to self inflicted injury or injury inflicted by another; and only if the child welfare system might have contributed in some way to the death or injury. Critical injuries are those that are life-threatening, or cause serious or long term impairment.

Reason

Focusing child death review on child deaths where there is an apparent link to the child serving system will be a more productive use of the Representative's time and resources.

Recommendation 6

6

That legislation permit the Lieutenant Governor in Council or the Standing Committee to refer a death to the Representative, leaving it to the discretion of the Representative to determine whether to undertake a review or not, and to report to Cabinet.

Reason

There may be individual child deaths or critical injuries that have broader child welfare or social policy implications where a causal link to the child serving system is not readily apparent.

Recommendation 7

7

That the Representative have powers of a Commissioner of Inquiry under the Inquiry Act.

Reason

The Representative from time to time may need to compel evidence for the purposes of the review of a child death or injury.

Recommendation 8

8

That the Representative be mandated to report to the Minister, the Legislature and the public through annual reports and special reports. This reporting will include reporting on compliance with recommendations, by the Ministry and other public bodies.

Reason

Public reporting holds the Representative accountable to the Standing Committee, the Legislature as well as the public. Public reports can also promote improvements to the child serving system.

2.4 OTHER PUBLIC BODIES

The Ministry of Children and Family Development has lead responsibility in our child welfare system, and the new Representative for Children and Youth will be the independent agency with a primary oversight role. But there are other public bodies with important, if more limited, roles to play.

Coroners Service

The Coroner's role in investigating all unexpected and unexplained deaths of course extends to children's deaths as well. The office has long experience in death investigations, including the immediate circumstances and the means of death. In recent years it has addressed the unique challenges posed by investigation of children's deaths—especially very young children—and developed a detailed information gathering tool, which it refers to as its child death protocol. The Coroner has also improved and expanded its quality assurance function respecting child death investigations.

It should continue to fulfill these functions, including training local and regional coroners in the use of the protocol. The results of its investigations in cases of children who are in care, or who have been served by the Ministry, will be useful information for the new Representative.

Investigation of suspicious deaths is the traditional role of the Coroner and the focus of the mandate conferred on the office by the *Coroners Act*, but over the years the Coroner's practice has expanded to one that is geared more towards prevention. Under a memorandum of understanding with the Vital Statistics agency, the Coroner now receives notices of all deaths. In 2004 the Child Death Review Unit of the BC Coroners Service published a study of infant deaths and a set of guidelines for parents on safe sleeping practices for babies.

I support this expanded role for the Coroner. That office is well placed to identify trends that emerge from the data that its investigation work produces. This perspective will be a valuable contribution to the multidisciplinary teams that will assist both the new Representative and the Ministry. (Local coroners will contribute to the work of the Ministry's case reviews in the regions, with the Regional Coroner being brought in as necessary. I expect that the Chief Coroner would be a member of the more permanent multidisciplinary team that would support the Representative's review of select cases.)

There will be some similarity between the roles of the Coroner and the proposed Representative. Both will review and investigate child deaths that are suspicious, unexpected and unexplained.

The Representative's purpose is to oversee the child welfare system and, with respect to the death or injury of a child in care, or who had been receiving Ministry services, it is to ensure that if there was any causal connection between the adequacy of services or child welfare practice and the death, that this is addressed. The Representative's primary purpose is to improve practices, policies and service delivery in the child welfare system.

The Coroner investigates all unexplained, suspicious and unexpected child deaths, including those of children within the child welfare system. The Coroner's purpose, however, is not to oversee the child welfare system. It is to explain why a child has died unexpectedly. The investigation focuses on the circumstances surrounding the death. In contrast, the Representative's investigation is broader and will include an examination of a child's relationship with the child welfare system.

Given the similar, but different, roles of the Coroner and the Representative, it is critical that the two bodies work in a collaborative, organized way to support these mutually compatible roles that are intended to improve the health and wellbeing of children.

The Chief Coroner should continue to report to the Deputy Minister of Public Safety and Solicitor General. For clarity's sake, a letter of expectation should be developed, in concert with the Chief Coroner, setting out the government's expectations for the Chief Coroner, with identification of priorities and performance measures.

One important expectation should be to ensure that the Coroners Service establishes and maintains effective cooperative relationships with the Ministry and other public agencies. The Coroner may refer particular cases to either the Representative or the Ministry for consideration of a further review; and should collaborate with the Ministry and other agencies, including the Public Health Officer, the Public Guardian and Trustee, and the Ministry of Health to provide public information and advice that can help to prevent future deaths. The Coroner should develop protocols with other agencies to minimize duplication of efforts.

Government should review the *Coroners Act* to bring it into line with the modern day functioning and expectations of this office, and to ensure that it has the legislative tools it needs to do its work effectively.

With respect to budget, the Coroners Service was never funded to a level that would permit it to fulfill the responsibilities it was given in 2002 for child death reviews. It could be argued that the Service has been chronically under-funded, even for the performance of its more limited role in death investigation.

The recent funding announced in *Budget 2006* for the Coroners Service in the child death investigation area seems to be an appropriate bolstering for this function.

The Child Death Review Unit within the Coroners Service should remain in place, with appropriate funding and resources. This specialized unit will support the work of the Ministry and the Representative and will further our understanding of the causes of child death.

Recommendation 9

9

That the child death investigation function, with funding as reflected in Budget 2006 be continued.

Reason

The investigation and determination of the circumstances and cause of death is an important first step in the child death review function. The Coroners Service has addressed the particular challenges of investigating child deaths, with its child death protocol, and this will provide valuable information to the Ministry, the Representative, and others.

Recommendation 10

10

That the Child Death Review Unit within the Coroners Service continue.

Reason

This unit is well-placed to ensure ongoing improvements to child death investigations through the maintenance of quality assurance standards, advice, consultation and training for local coroners.

Recommendation 11

11

The *Coroners Act* should be updated, in line with the Coroner's role today; and expectations of the office should be clarified.

Reason

The role of the Coroner has changed over time and public accountability requires a better understanding on all sides of what is expected from the Coroners Service.

The Ombudsman

I make no recommendations for change to the mandate and roles and responsibilities of the Ombudsman.

The Ombudsman's Office should monitor its workload to determine if the changes recommended in this review result in increased demands on that office. If there in an increase in requests for help with administrative fairness issues in the child welfare system, the government should consider an increase in its funding to support this activity. This office provides a final review of the fairness of processes that affect children, youth and families who are often very vulnerable. It is an important component of the overall oversight and quality assurance function for the child welfare system.

Public Guardian and Trustee

The Public Guardian and Trustee made detailed submissions to my review and provided interesting insights into that office's work and how it supports the interests of children and youth in care. Those submissions included a number of recommendations for legislative amendments. I was not able, in the time allotted to my review, to fully consider these recommendations and the broader public policy implications of some of them. However, I do think many of these proposals have merit. I encourage the government to conduct a review of the Public Guardian and Trustee Act in its entirety. It is antiquated legislation, greatly in need of updating.

In particular, I draw government's attention to the proposal for a legislative amendment to compel the Director of child welfare to report promptly to the Public Guardian and Trustee all critical incidents and any circumstances that may give rise to a legal claim by or against a child in the care of the Province. It is the duty of the Public Guardian to protect the legal interests of these children and it cannot do so without this information.

The core services review recommended a protocol between the Provincial Director of child welfare and the Public Guardian and Trustee to ensure that this information is provided. That was in 2001. To date, I understand that a protocol is still not in place.

While I am loathe to recommend legislative amendments of a purely administrative nature, I am compelled to do so in this situation, to enable the Public Guardian to carry out its statutory obligations to children.

The Public Guardian also emphasized to me the need for greater cooperation, coordination and information sharing among all child serving agencies, including the Ministry. I fully support these suggestions.

I make no recommendations for change to the role of the Public Guardian and Trustee in providing protective and trust services to children in care of the Ministry.

The Office for Children and Youth

The Office for Children and Youth has played an important role in bringing to the attention of the legislature and the child welfare system, important issues such as suicide among Aboriginal youth, and child and youth mental health.

She has collaborated with other public bodies to combine information from multiple sources to lead us to better understanding of the lives of children and youth. These are the kinds of initiatives that I encourage the new Representative to undertake.

The Office did not have the status of an Officer of the Legislature and this may have hampered its ability to engender public confidence.

The Office also had a limited mandate that restricted its ability to advocate for individuals, which is a function that children, youth and families in the child welfare system clearly want and need.

Despite these limitations the Office has made a significant contribution to public understanding, as evidenced by the many thoughtful and useful publications that are posted on the Officer's website.

I am confident that, in the interests of children, the Officer and her staff will support the transition to the new body with the high level of professionalism and commitment that they have shown to date.

Public Health Agencies

The Public Health Officer plays a key role in research, analysis and reporting on public health issues, including those particularly affecting children, and children in care.

I have learned that the Population Health and Wellness Branch of the Ministry of Health has an injury prevention unit that could well contribute further to our understanding of intentional and accidental injuries. This unit, in concert with the BC Injury Prevention Research Unit, has established an Intentional Injury Surveillance Network, with members from the health and child welfare sectors, universities, and the Coroner's office. The network has recently received a grant to research intentional injuries of children under one year of age. This is the beginning of an examination of injuries for all age groups up to the age of 19. I see potential here for future collaboration with the Representative in the area of child injury and death reviews.

These public health bodies should continue to be supported in this important area of work as it provides a broader understanding of risks to all children, and children in care, who are a particularly vulnerable group. From this greater understanding can come strategies for prevention.

3

Keeping Aboriginal Children Safe and Well

KEEPING ABORIGINAL CHILDREN SAFE AND WELL

☐ Aboriginals and the Child Welfare System
☐ Strong Families and Communities
☐ Hearing Aboriginal Perspectives
☐ Transferring Governance
☐ Delegating Powers
☐ Aboriginal Face for New Representative
☐ Recruitment

3. Keeping Aboriginal Children Safe and Well

3.1 OUR HISTORY

For generations before European contact, Aboriginal people in North America nurtured and protected their children in extended families and communities. Yet today, Aboriginal children are being taken into care in British Columbia at a steadily rising rate. An Aboriginal child today is 9.5 times more likely to be in care than a non-Aboriginal child, and half the children in care in the province today are Aboriginal.[9]

The explanation is rooted in our shared history. BC's Provincial Health Officer, in his 2001 Report on The Health and Well-being of Aboriginal People in British Columbia, put it this way:

> *The high rate of Aboriginal children in care reflects the historical disadvantages experienced by Aboriginal communities. Residential schools caused generations to grow up without opportunities to develop parenting skills. Poverty, relative isolation, unemployment, and inadequate housing all contribute to family disruption. When Aboriginal families experience difficulties, they have not always been given the resources and support they need to ensure that children are raised in their home communities and culture.*

For about a century, the federal government in partnership with various religious organizations operated residential schools across the country, with effects on Aboriginal communities that by now are well known. In 1998, the Government of Canada responded to the report of the Royal Commission on Aboriginal Peoples with a Statement of Reconciliation, acknowledging its role in developing and administering residential schools. It said, in part:

> *This system separated many children from their families and communities and prevented them from speaking their own languages and from learning about their heritage and cultures. In the worst cases, it left legacies of personal pain and distress that continue to reverberate in Aboriginal communities to this day.*

I speak from experience when I add my voice to those assessments. The Indian residential school program, with its history of abuse and its negative attitude towards all things "Indian," has had devastating consequences for the Aboriginal people of our province. The sad experience of many who attended these schools has had such an inter-generational effect on children and grandchildren that I have no hesitation in laying a significant portion of responsibility for today's unacceptable level of involvement of Aboriginal families in our child welfare system on the doorstep of that ill-conceived program of years ago.

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[9] Source: Presentation to Children and Youth Review by the Ministry of Children and Family Development, January 28, 2006.

As I continue to give leadership, as I have since 2003, to a national initiative aimed at bringing resolution to this blight on the pages of Canadian history, I am confident that the day will come when its cancerous effect will be remedied, though never forgotten.

3.2 ABORIGINAL PEOPLE AND THE CHILD WELFARE SYSTEM

In its early days, the province's child welfare system had little involvement with Aboriginal families. This was partly due to the peculiarities of Canada's constitutional framework: while the federal government is responsible for status Indians on reserve lands (where most Aboriginal people then lived), child welfare is a provincial responsibility. For a long time this split jurisdiction and disagreements over who would pay meant that neither level of government was prepared to provide child welfare services to Indians living on or off reserve. Dual jurisdiction continues to cause problems for Aboriginal child welfare services, as discussed later in this chapter.

In 1951, amendments to the *Indian Act* meant that provincial child welfare laws and programs would apply to "Indians" but still there was no federal funding to support these new provincial responsibilities.

Indian residential schools were being closed down in the 1960's and 70's but by then large numbers of Aboriginal children were being removed from home, not for schooling but for placement in foster care and group homes. The 'Sixties Scoop' was the phrase coined by Patrick Johnston in his 1983 report for the Canadian Council on Social Development. It referred to the rapid rate of child apprehensions that increased the number of Aboriginal children in care in BC from 29 in 1955 to 1,446 in 1964.

Those numbers are dramatic, but they do not capture the heartache of parents and children taken from each other, and the lasting effects on extended families and communities when children are removed.

The following graph[10] shows two converging trends: the steady decline in the number of non-Aboriginal children in care in BC, against the rising number of Aboriginal children. This can be explained in part by changing demographics and the younger populations in Aboriginal communities. But whatever the explanation, it highlights the pressing need for the child welfare system to pay attention to Aboriginal children and families and find better ways to respond to their needs.

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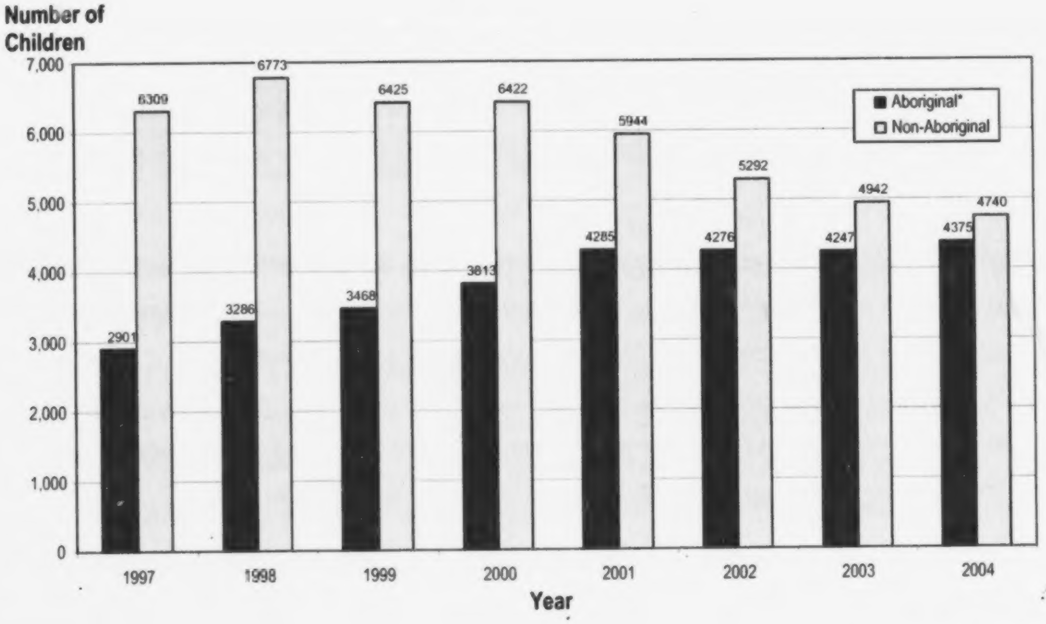
[10] Source: Ministry of Children and Family Development, accessed through BC Vital Statistics Agency.

Fig 1. - Numbers of Children and Youth in Care in BC, by Aboriginal Status



3.3 STRONG FAMILIES AND COMMUNITIES KEEP CHILDREN SAFE

A narrow focus on safety can obscure the social context in which child protection cases arise. Unemployment, poor housing and poverty can fuel alcoholism, drug abuse, and violence that put children at risk in their homes.

In British Columbia, as elsewhere, most child protection cases arise within families that are materially disadvantaged: almost half either are on income assistance at the time when a child is apprehended, or have recently been. Almost half are also Aboriginal although further statistical study shows that among low-income families, child protection reports are no more frequently made about Aboriginal families than about non-Aboriginal families. In other words, the factors that result in child protection cases are closely linked to the social and economic conditions of families and communities.

The challenge facing us all is to reduce the number of Aboriginal children who are at risk of harm by finding ways to make sure their families and communities are in a position to keep their children safe and well. It seems clear by now that the answers do not lie wholly, or evenly mainly, in the child protection system. Rather, the solutions lie in building strong, economically viable and culturally robust communities[11].

National Aboriginal leaders and Canada's first Ministers recognized this fact at Kelowna in November, 2005, when they signed the Kelowna Accord, committing themselves to a 10-year plan to close the gap in the quality of life enjoyed by Aboriginal people and other Canadians.

With that in mind, British Columbia began discussions in 2005, aimed at a new relationship with First Nations people. The province has set goals for British Columbians' education, health and fitness, and employment levels; for environmental quality; and for support services for persons with disabilities and special needs, seniors and children at risk. It recognizes that these goals will only be met for the province when they are achieved for its Aboriginal people, and that will happen only when they become strong economic partners in the province and the country.

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[11] Dr. Clyde Hertzman, Director of the University of British Columbia's Human Early Learning Project (HELP), has demonstrated the impact that poverty, poor housing, and unemployment have on healthy outcomes for children and youth in BC.

This new relationship, the ongoing resolution of the Indian residential schools issue, and the focus being placed by the Kelowna Accord on housing, education, health and economic opportunity, put us in a better position today than we have ever been, to finally reverse the conditions that cause so many Aboriginal children to need protection and to bring their numbers into line with the general population, or better.

I applaud the efforts to date by Aboriginal leaders and the federal and provincial governments, and encourage them in the pursuit of these goals. The road ahead will require collaboration not just between governments, but among all government departments that address the social and economic needs of families.

I suggest that as a first step towards fulfillment of the Kelowna Accord, the provincial and federal governments, in collaboration with Aboriginal communities, undertake an assessment of the health, economic and social needs of BC's Aboriginal communities, and particularly of small rural communities. This would allow for development of community plans to serve as roadmaps towards achievement of the Accord's 10-year goals.

Although small communities, especially in remote locations, have particular needs, a minority of Aboriginal people live on reserves. I encourage the provincial government to expand the scope of its new relationship beyond the current focus on First Nations reserve-based Aboriginals. If these new initiatives are to have significant impact, they must provide opportunities to Aboriginal families in urban communities and communities of all sizes, whether on or off reserve.

Recommendation 12

12

That the provincial and federal governments, in collaboration with Aboriginal communities, begin work towards fulfillment of the commitments of the Kelowna Accord by assessing the health, economic and social needs of Aboriginal communities, including urban, off-reserve populations.

Reason

Needs assessments can form the basis of community plans for closing the gap in quality of life between Aboriginal and other British Columbians, which will mean stronger, safer families and communities for children.

3.4 HEARING ABORIGINAL PERSPECTIVES

Aboriginal perspectives are diverse, but one message is clearly delivered: Aboriginal people want and need to be actively involved in developing policies that affect them, and in delivering services to their communities.

BC's *Child, Family and Community Service Act* sets out service delivery principles:[12]

- Aboriginal people should be involved in the planning and delivery of services to Aboriginal families and their children;
- services should be planned and provided in ways that are sensitive to the needs and the cultural, racial and religious heritage of those receiving the services; and
- the community should be involved, wherever possible and appropriate, in the planning and delivery of services, including preventive and support services to families and children.

The *Act* also says that if the child is Aboriginal, the importance of preserving the child's cultural identity must be considered in determining best interests.[13]

The determination of "best interests" in the case of an Aboriginal child can challenge all of us to understand and appreciate differing cultural perspectives. For example, Aboriginal children living in traditional communities benefit from a rich network of family and community relationships that offer support and also an expectation of behaviour. While we have an obligation to attend to the safety and well being of the individual child, and many have flourished in non-Aboriginal homes, Aboriginal people generally see it as extremely detrimental to a child's best interests to remove children from their communities. These ties would be a much more significant factor, from an Aboriginal perspective, than would economic, educational and other opportunities.

The 2001 final report of Manitoba's Aboriginal Justice Implementation Commission had this to say:

> *In examining these differences, it becomes clear that interpretations of best interests of children are culturally bound, and not universal. Aboriginal views of the best interest of the child, or, for that matter, the views of any culture, can conflict with non-Aboriginal views. Such differences are legitimate and should be respected.*

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[12] s. 3(b), (c), and (e)

[13] s. 4(2)

This is not to say that the safety of an Aboriginal child, or any child, will ever take a back seat to any other considerations. Child safety is job one and it is the law in British Columbia. However, there are many paths to the same goal and many ways of defining safety.

3.5 TRANSFERRING GOVERNANCE TO ABORIGINAL AUTHORITIES

When BC's Ministry of Children and Family Development began exploring the transfer of child welfare governance to five regional authorities, Aboriginal communities were concerned about how they would fit into that plan. In 2002, the Ministry and Aboriginal leaders agreed to pursue the development of five parallel but separate Aboriginal child welfare authorities. A Memorandum of Understanding has been signed and some work has been done to prepare for transfer of responsibility for the care of Aboriginal children, but much work remains. At this point, I understand that enabling legislation is on hold, pending further consultation with the Aboriginal community.

If this process is to be carried forward in the future, it will need a clearly articulated vision, developed through active community consultation.

This applies to decentralization generally (as discussed in Chapter 4) but most especially to Aboriginal communities because of their diversity of interests and community conditions. My terms of reference do not make particular reference to child welfare in the Aboriginal context, but with the numbers of Aboriginal children in the system and the special challenges facing Aboriginal agencies, which I discuss below, I cannot help but pay particular attention.

It has been beyond my mandate, and would require more than the time allotted to me, to fully delve into the matter of the eventual transfer of governance over child welfare to five Aboriginal authorities as set out in the Tsawwassen Accord. I leave that for others. But I do know that it is a controversial issue among Aboriginal people with experience in this field. It is energetically supported by some. Others fear that the level of responsibility could be overwhelming, at least in the foreseeable future, when their communities face so many other challenges as well. Still others argue that it will take many more than five authorities if boundaries are to make sense in the context of Aboriginal territories and are to recognize their nation status.

There are other governance models that may be examined. Manitoba, as one example, recognizes the needs of the large number of Aboriginal people living off reserve and provides them with a broad range of services. Four province-wide child welfare authorities have concurrent jurisdiction: two First Nations (northern and southern), one Métis, and one general, and Aboriginal people receiving child welfare services may choose the authority they prefer.

In British Columbia, consideration could be given to strengthening the ties between Aboriginal agencies and the Ministry's regional offices, which might be a more natural source of support in some respects than the provincial headquarters in Victoria.

Arriving at a governance model that best serves the real interests of Aboriginal children, families and communities may take more time than some would like, but it is worth taking the time to get it right.

What I can say with confidence is that when decisions are made, they must be made with the full involvement of Aboriginal people themselves.

I recognize that people need quality services in the meantime and later in this chapter I set out the steps that need to be taken to strengthen the current delegated Aboriginal agencies so that they are able to carry out their child welfare responsibilities as effectively as possible. I also propose guidelines for decentralization, which apply as much to the Aboriginal context as to the non-Aboriginal regions.

Recommendation 13

13

That the provincial government actively collaborate with Aboriginal people to develop a common vision for governance of the Aboriginal child welfare system; and whatever Aboriginal child welfare model evolves from that process must be the subject of active and widespread community consultation before its enactment.

Reason

Aboriginal people alone truly understand their communities and the needs of their children and families, so it makes sense that, with the support, expertise and experience of the Ministry, and working in partnership, their own wisdom and understanding should guide the way to any change in the governance structure of the child welfare system that serves them.

3.6 DELEGATING POWERS TO ABORIGINAL AGENCIES

Transfer of responsibility for service delivery has its own challenges but is less complex than transfer of governance responsibilities, and is progressing more rapidly. Since 1980, government policy has provided for delegation of certain powers by the provincial government to Aboriginal agencies.

Many individual bands and intertribal councils have, through a tripartite agreement with the federal and provincial governments, created child welfare systems to provide services to their band members living on reserves. Today, 156 of the approximately 200 First Nation bands in BC are represented by agencies that either have, or are actively planning toward, delegation agreements to manage their own child and family services.

Delegation agreements are negotiated between a band and the federal government, but the provincial Director of child welfare does not sign an agreement until the Ministry's criteria are met. This involves an examination of the agency's governance structure, policies, service delivery plan, conflict resolution process, complaint process, facilities, human resources plan, financial management, records management communication and community needs assessment.

Delegation is a graduated process. Agencies begin at a level of delegation that allows them to find foster homes and other resources, and provide voluntary support services to families. As they demonstrate competence and readiness, they receive more responsibilities. At the next level, they assume responsibility for the guardianship of children in care. In law, the Director of child welfare remains the guardian of the 1,340 or so Aboriginal children who are in the care of Aboriginal agencies, but on a day-to-day basis, guardianship is handled locally. The final level of delegation gives an agency all the duties and powers that a Ministry social worker would have, including authority to investigate reports and remove children and take them into care. Training is provided at each level, under contract, by Caring for First Nations Children Society.

The process of moving to full delegation takes time and some agencies may never, either because their community is too small, or because their members have no wish to take on full authority and responsibility. Currently, 23 delegated agencies in BC are at the start-up stage or operating with one of three levels of delegation. Only seven of them are fully delegated. Even with full delegation, agencies are still governed by provincial legislation.

Aboriginal Agencies Need To Be Strengthened

In British Columbia just under a third of Aboriginal children in care are looked after by the 23 delegated Aboriginal agencies, while another 15% have been placed by the Ministry in Aboriginal homes. This is a positive and growing trend towards increasing involvement of Aboriginal families and agencies in caring for Aboriginal children who need protection.

But the fact remains that more Aboriginal children receive care from the Ministry than from the delegated agencies and Aboriginal foster families combined. Given the slow pace of delegation to

Aboriginal agencies, this is likely to be the case for some time.

The Ministry needs to speed the transition by proactively supporting development of greater capacity in Aboriginal agencies and in its own Aboriginal teams working out of Ministry offices.

I heard from many sources about the difficulties facing delegated Aboriginal child welfare agencies. Some of these difficulties arise from a lack of resources but others result from jurisdictional issues, and still others reflect the fact that these agencies often work in small, isolated communities with overwhelming social problems.

Jurisdictional Issues Cause Unnecessary Problems

For example, children in care often have complex health issues requiring services that may or may not be covered by Health Canada, or alternatively, by Indian and Northern Affairs Canada. An inordinate amount of a small agency's time and energy can be taken up dealing with such gaps and overlaps. Other conflicts can result from the ways that the federal and provincial governments divide responsibility for Aboriginal child welfare, especially when families move on and off reserve.

Governments and government departments need strategies for minimizing these jurisdictional gaps, overlaps and conflicts but when difficulties arise, the Representative for Children and Youth, which I recommend in Chapter 2, can help the parties arrive at a resolution and, if needed, can advocate on behalf of a child or family.

The federal government funds services provided on reserves, and this causes disparities between these and provincially funded services off-reserve. The federal government's funding[14] for reserve-based child welfare services was developed at a time when there was not so much emphasis on prevention as there is today, and is calculated largely on the basis of the number of children taken into care. It provides little or no funding for the kinds of family support services that might enable a child to be kept safely at home.

This funding formula has been debated for some years and recommendations for change have been accepted but not yet implemented. It is time for the federal government to change this formula. This has been the provincial government's position and I encourage them to pursue the matter vigorously.

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[14] Pursuant to 1991 Federal directive (Directive 20-1), which charts the development process, funding formulas and operational structure of First Nations child welfare services.

Recommendation 14

14

That the provincial government work with Canada to clarify their respective funding responsibilities, remove jurisdictional obstacles facing Aboriginal child welfare agencies, and replace Directive 20-1 with a new approach that is more supportive of measures that protect the integrity of the family.

Reason

Agencies should be free to concentrate their efforts and resources on the important work they need to do in their communities, without unnecessary impediments caused by jurisdictional gaps, overlaps and conflicts and by funding formulas that do not support good child welfare practice.

Agencies Need Resources

Aboriginal child welfare agencies in many cases face greater obstacles than non-Aboriginal agencies and yet do so with fewer resources. Some operate in small, remote communities that do not have the level of health, educational and social services that exist elsewhere. And whether in small communities or in downtown Vancouver, Aboriginal agencies can find in their caseloads some of the most challenging cases, as a result of poverty, substance abuse and other social ills.

I support the principle that Aboriginal communities should have greater control of delivery of services to children and families, but it has to be done with the resources that the work requires.

The needs are simple, but they are acute.

- They need office management systems and skills.
- They need computer equipment and internet access so they can track cases, share information, and communicate quickly and effectively with other agencies.
- They need access to the same training opportunities provided to Ministry staff, as well as special training directed to their particular needs.

I heard about the emotional impact to the staff of any child welfare agency when a child known to them comes to harm. Fortunately, these are rare events, but they can be devastating when they occur, and the staff have a caseload of other children they must continue to serve. There is a need for an Aboriginal team who can come immediately to the assistance of an agency facing an event such as the death of a child and help to restore the agency's confidence in its own practice.

Recommendation 15

15

That the provincial and federal governments provide Aboriginal agencies with:

- modern information technology and help them acquire appropriate office management systems and skills;
- the same training opportunities as are offered to Ministry staff, as well as specialized training directed at their particular needs; and
- support during a crisis from an emergency response team.

Reason

Aboriginal agencies face many challenges in their work: to make effective use of scarce resources, they need to be supported by efficient office management and systems, and they need first rate professional skills. They also need special support at times of crisis, because small agencies cannot themselves provide for these rare events.

3.7 AN ABORIGINAL FACE FOR THE NEW REPRESENTATIVE FOR CHILDREN AND YOUTH

In Chapter 2 I recommend the establishment of a new Representative for Children and Youth. This organization will serve a constituency of which Aboriginal children and families form a large part, and it will be essential to its legitimacy and its success that Aboriginal people see it as a place where they will be welcome and understood, and where traditional Aboriginal understanding and practices have a place.

I am recommending that this new organization be headed by a Representative and two Deputies, one for advocacy and one for monitoring of the child welfare system. At the very least, one of these three senior people must be Aboriginal.

When I say "Aboriginal" I mean not only a person of Aboriginal heritage, but one with a track record of involvement in Aboriginal communities, who understands Aboriginal children and youth, and has direct experience or at least a deep understanding of life on a reserve.

This is important for several reasons. First, of course, is the understanding that comes from experience, of what life is like for Aboriginal children and families in British Columbia. This level of understanding will inform the process of setting meaningful goals and priorities for the organization. Second, I was told by an Aboriginal person that "we often don't like to contact an organization that doesn't look like us." If this new body is to be an effective advocate for them, it needs to be truly accessible to them. Third, there are nuances to life in an Aboriginal community, especially on reserve, family dynamics and relationships between band councils and service delivery agencies that are not always well understood by others and some of which do not promote the delivery of services to a professional standard. An Aboriginal person with real life experience in an Aboriginal community can speak from a place of respect that allows for the delivery of tough messages, when that is what is required.

I also recognize that one or two people alone cannot fully represent or reflect the rich diversity of experience and perspectives of diverse Aboriginal communities.

The new organization will need to make a concerted effort to recruit and retain Aboriginal staff at all levels. I also urge this new body, when setting its goals and priorities and pursuing its mandate, to consult in a meaningful way with Aboriginal communities around the province, both on reserve and off, rural and urban, and including Aboriginal youth.

Recommendation 16

16

That at least one of the three senior positions at the new Representative for Children and Youth be held at all times by an Aboriginal person; and that the Representative actively recruit some Aboriginal staff at all levels of the organization.

Reason

The new body must have Aboriginal people at senior levels if it is to be seen as truly accessible and credible to Aboriginal people, and, with a constituency that is at least half Aboriginal, can only be fully effective if it is guided by people with a true understanding of Aboriginal values, culture and communities.

Aboriginal Recruitment in the Ministry

The Ministry is where priorities and budgets are set and plans and strategies for future directions are developed. If these are to reflect Aboriginal needs and priorities, the Ministry has to have more Aboriginal people on its staff at all levels, so that the Ministry can benefit from their perspectives and insights. I am given to understand that it has been easier to attract Aboriginal people than to keep them for substantial periods. If that is the case, there needs to be an examination of the reasons why people leave. Consultation with Aboriginal people in the field and those who have left it; and with schools of social work and others may lead to more effective strategies for ensuring that the workforce of the Ministry itself more accurately reflects the people that it most often serves.

Recommendation 17

17

That the Ministry of Children and Family Development find ways to recruit and retain more Aboriginal people for service in the Ministry, at all levels, but particularly among social workers who deal directly with children and families.

Reason

The Ministry should reflect the cultural background of the people it serves and should be informed in its work with Aboriginal people by an understanding of child, family and community needs that comes from life experience.

4

Ministry of Children and Family Development

MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT

- ☐ Decentralization
- ☐ Quality Assurance and Accountability
- ☐ Internal Review of Child Injuries and Death
- ☐ Modern Approaches to Child Protection

4. Ministry of Children and Family Development

4.1 DECENTRALIZATION

What "Decentralization" Means

Tension between centralizing and decentralizing forces has characterized British Columbia's child welfare system for some time. In a province as large as British Columbia, a decentralized model allows for a closer match of services and programs to the unique needs of widely dispersed and diverse communities. On the other hand, centralization of authority and resources promotes uniformity of standards and allows for continuity of service to families who move from one part of the province to another. It also puts more control in the hands of the executive and political leaders who will ultimately be held responsible for the serious consequences that can flow from a system failure.

I use "decentralization" to describe the process of moving responsibilities, resources, and authorities from the central agency (headquarters) out to the five regions, and eventually to Aboriginal authorities. This process has been underway in British Columbia for some time, with most child welfare services being delivered through local offices in more than 50 communities. At a more advanced stage of decentralization, community participation is formalized in the creation of governance bodies, such as the existing health authorities.

Decentralization is sometimes seen as an offloading of responsibilities without a commitment to corresponding funding, and recent history offers some support for that view. A significant budget reduction was targeted for the child welfare system in 2002, at the same time that quality assurance, audit, and child death review functions were being transferred to the regions.

All in all, the relationship between the regions and headquarters has evolved without a guiding plan or apparent strategy. The process of decentralization that has occurred to date has proceeded in fits and starts, with some regions moving actively to implement new ways of working.

Other regions have moved more slowly, and headquarters has yet to embrace the ideal of program integration that was the driving force behind the Ministry's creation.

Uneven Progress

Having said that the process of decentralization is well underway, I must add that it has not sailed a straight course.

Before 1995, child welfare services were delivered by the Ministry of Social Services through 11 regional offices, with a single provincial Superintendent of Child Welfare, and policy, standards and quality assurance functions located in the Ministry's Victoria offices.

The Gove Inquiry recommended a single ministry for children, youth and families and delivery of child welfare services through a community-based model, to be governed by about 20 regional child welfare boards.

In response to those recommendations the new integrated ministry was established and, in preparation for regional governance, it organized service delivery into 20 relatively autonomous regional operating agencies, matching the then boundaries of the health authorities.

In 1997, the northern regions were amalgamated, reducing the number of regions to 18, each under the direction of a Regional Operating Officer who reported directly to the Deputy Minister.

A new Deputy Minister in 1998 brought the ministry back to a more traditional model, with less autonomy for the regions, and a push for more consistency among them. The Regional Operating Officers no longer reported to the Deputy, but to an Assistant Deputy Minister.

In early 1999, the Ministry's 18 regions were reorganized into 11. The Regional Operating Officers became known as Regional Executive Directors

Then, in 2000, the Deputy Minister of the Ministry of Attorney General (who had been the Transition Commissioner and first Children's Commissioner) was called upon to resolve an impasse between the Ministry and the Children's Commission involving a foster care placement.

The Deputy's report recommended that a Director of child protection be appointed for each region, to provide a stronger link to communities, though it didn't happen right away:

> *"In BC there are 10,000 children in care. It is not possible that the level of attention to children, relations to foster or natural parents, direction to staff and a sense of community needs can be managed by a sole director of child protection for this province."*

A result of the new government's core services review in 2001 was the decision to go ahead with five regional authorities for child and family development; one provincial authority for community living services (for adults and children with developmental disabilities); and to consult with Aboriginal communities on a model for their children and families.

In 2002, the Ministry realigned its 11 regions into five, coinciding with the new health regions, and the Minister designated a Director of child welfare in each. Responsibilities for quality assurance were transferred to the regions and citizens were appointed to five regional committees to plan for decentralization. A consultation with Aboriginal political leaders brought a commitment to support five separate Aboriginal authorities.

During 2003, work on planning for regional governance was put on the back burner as the Ministry turned its attention to meeting its budget reduction targets.

In the spring of 2004, the new Minister disbanded the five regional planning committees, and the Ministry's finite planning resources were focused on the Aboriginal agenda.

This review arises at a time when the Ministry is again considering the establishment of five regional authorities, and five Aboriginal authorities as well, and the transfer of significant responsibility and resources to each of them.

Conditions for Decentralization

I believe it makes good sense to engage local communities in service delivery and resource allocation, within a regionally based governance model. Equally important is ensuring that standards and policies apply consistently throughout the province. I have not had the time, nor the mandate, to develop and recommend a new model for community-based governance of the child welfare system, but I do have some observations on some essential elements, and some general thoughts on what I believe is the appropriate role for the Ministry in a decentralized governance structure.

Earlier I described the "stop and start" process that has characterized government's approach to decentralization. Government's commitment to change rarely lasts long, regardless of the political party in power.

We are all aware how challenging it is to bring about massive change to entrenched systems. Even in ideal circumstances, change of the magnitude contemplated here, would be taxing. Unfortunately, the circumstances within which government has attempted to accomplish decentralization have been far from ideal.

These are guidelines that I believe will aid in moving forward on the road to decentralization.

- The political leadership must demonstrate a clear and continuing commitment to decentralization. This may easier said than done. System failures are bound to occur as decentralization progresses. Government needs to be prepared and be able to respond quickly. And, it must continue to move decentralization forward.
- Decentralization cannot be done off the side of a desk. It requires a dedicated team, and resources. It requires adequate time for consultation and input. It cannot be accomplished in an environment of instability and ever-changing priorities. Budget stability is essential.
- Decentralization must be undertaken as a partnership between the Ministry and communities, with representation and participation of both in the development of the decentralization plan. This applies as well to the development of Aboriginal authorities.
- Responsibilities for governance should be transferred to the regions only when they have demonstrated the ability to carry them out. In perhaps two years time, it should be possible to establish baselines and measure a region's performance against those. When the region's performance reaches an acceptable level, a Management Charter could define the new authority's area of responsibility and set performance targets.

There are a number of models that can be studied. Ontario has a long history of community-based service delivery. Alberta, once a centralized model, moved to a fully decentralized model in the mid-90s but has been slowly expanding the provincial role. Manitoba now has 4 authorities acting as oversight bodies for the agencies under their mandates. The province works with the authorities in a supportive, consultative way but still has overriding authority. BC's health authorities are another model to be considered.

The roles and responsibilities of Ministry headquarters and the Authorities need to be clearly articulated, both in legislation and policy, to minimize conflict and confusion into the future. At present, the distinction between the roles and responsibilities of the provincial and regional directors of child welfare are not at all clear.

The Headquarters Role

In my view, there will always be an important role for the Ministry's headquarters in Victoria, even in a highly decentralized model. Services such as research, evaluation, monitoring, and quality assurance have been considered luxuries when program budgets were stretched to the limits. Now these services need to be significantly strengthened. They will pay dividends in the future, not only because they will contribute to the Ministry's ability to fulfill its mandate, but because they will allow the Ministry to compete more successfully for scarce government resources by demonstrating the efficacy of its programs and services.

Recommendation 18

18

That the Ministry and community representatives jointly develop a plan for decentralization, beginning with a set of principles that will guide the process, a clear statement of expected results, and a course of action to achieve those results.

Reason

Without a vision and a plan of action, it is difficult to gain commitment and harness the requisite energy and resources to complete the task.

Recommendation 19

19

That government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stability.

Reason

Decentralization is a complex process and cannot be successfully achieved without the necessary time, staff and resources.

Recommendation 20

20

That responsibilities be transferred to regions and to Aboriginal authorities once they have demonstrated their ability to meet key performance targets.

Reason

Only by measuring performance will the Ministry be assured that the regional or Aboriginal authority has the capacity required to perform as required under a fully decentralized model.

Recommendation 21

21

That the Ministry retain at its headquarters, the authority it needs to set and ensure compliance with provincial standards and to meet its responsibility for public accountability.

Reason

The Province retains ultimate responsibility for child welfare and must be accountable; British Columbians need to be assured of a consistent standard of service, wherever they live in the province, and whether they move from region to region.

Structure of the Ministry

Some aspects of the Ministry's organization that have an impact on its effectiveness have come to my attention.

Lack of Integration at the Centre

The structure of the Ministry's central office reflects to this day the haste with which the Ministry was first put together in 1996. For example, each program area is housed in a separate division, headed by a separate Assistant Deputy Minister. I understand that this segregated approach causes frustration when policies, standards and practice vary across divisions. On the other hand, the regions seem to have moved to a far more integrated model, compounding potential tensions between the regions and central office in applying policy, standards, and practice.

It is time to break down the "silos" for the sake of the integrated and cohesive approach to programs and services that was the original intent behind the creation of this Ministry.

Dual Reporting Lines

There are confusing and anomalous lines of authority within the Ministry that have resulted from the move towards decentralization, and that need to be clarified.

Historically, there has been only one Director of child welfare for British Columbia (formerly known as "Superintendent of Child Welfare."). The Director is designated under the *Child, Community and Family*

Services Act to carry statutory responsibility for the protection and guardianship of children and youth. In July, 2002, as a means of strengthening local decision making and as a critical step on the path towards regional governance, the Minister designated five additional Directors, one for each of the Ministry's five regions. (A sixth Director was added in 2005, with the creation of Community Living British Columbia.)

The Director's responsibilities as protector and guardian of children have traditionally been separated from managerial responsibilities, so that in making decisions about what is in the best interests of a particular child, the Director is not subject to bureaucratic pressures. This division of responsibilities was continued in the regions with the result that although front line workers and supervisors report up to the Regional Director of operations, they are also accountable to the Regional Director of child welfare, who delegates authority to individual social workers for functions performed under the *Act*.
The Child and Youth Officer has found that this can lead to tensions within the Ministry's senior management "that may find expression in conflicting messages to front line staff." [15]

Disconnected Reporting Lines

Each region is headed by a Regional Executive Director. The Regional Directors of child welfare report to their Regional Executive Directors, but the Regional Executive Directors do not report to the Provincial Director of child welfare. Instead, the Regional Executive Directors report to the Assistant Deputy Minister for Regional Operations. This anomaly has been addressed so far by appointing the same person as both the Provincial Director of child welfare and ADM for Regional Operations. Both those positions now are being filled on an acting basis, by a single individual.

I understand that to date, issues have been managed fairly effectively on the basis of the ability of the individuals in those positions to make it work. But there needs to be a clear understanding of where ultimate authority lies as between the regional Directors of child welfare and the Provincial Director. This is important, not only because conflicts may arise that cannot be resolved informally as they have been, but because the Minister's primary contact person on child welfare issues is the Provincial Director. The Minister has to have confidence in the Provincial Director, so that person has to have the means to ensure that the Regional Directors are doing their jobs as they should.

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[15] Jane Morley, QC, Child and Youth Officer for British Columbia: *Report to the Attorney General . . . on the Director's Case Review Relating to the Nuu-cha-nulth Child who Died in Port Alberni on September 4, 2002,* February 15, 2006

Anomalous Executive Structure

The Regional Executive Directors have responsibility for the full range of Ministry programs within the region, including child welfare, youth justice, mental health, and services to children with special needs, and yet they report to an Assistant Deputy Minister whose program responsibility is more limited.

This executive and leadership structure seems to have evolved over time in response to particular needs and issues. The Deputy Minister has five Assistant Deputy Ministers and one Associate Deputy Minister reporting to him, some with limited spans of control, while others are responsible for a broad range and number of programs and staff.

In some cases, similar or related functions are housed in different divisions. For example, accountability and quality assurance functions are scattered throughout the organization; planning functions are located in two different divisions; responsibility for regionalization is located in one division but regionalization related to Aboriginal authorities is in another.

Recommendation 22

22

The Ministry should examine its management structure to find ways to realign roles and responsibilities in ways that will clarify lines of authority and facilitate collaboration across program areas and between regions and the central office.

Reason

Confusion about lines of authority is an impediment to effective services to children; and better integration of program areas will support decentralization and promote a more comprehensive approach to meeting all the needs of the children, youth and families that the Ministry serves.

4.2 QUALITY ASSURANCE AND ACCOUNTABILITY

Measuring Performance

Performance management is about clarifying an organization's mandate, purpose, and goals and identifying how to measure its performance against those goals. Accountability is the obligation of those in charge to explain and report on how well the organization has carried out its responsibilities.

Under our system of government, a Minister is accountable to the Legislature for the effectiveness of his or her ministry; for ensuring that the right governance and organizational structures and processes are in place; and that the organization is led by competent staff.

A ministry's executive is accountable to its Minister for carrying out the ministry's business and operations. To measure its effectiveness in meeting its goals, a ministry establishes internal systems for monitoring, auditing, evaluating and taking corrective action as needed.

As the Ministry of Children and Family Development proceeds towards greater decentralization, accountability takes even greater importance. In a decentralized model, the regional and Aboriginal authorities will need to be very clear about what they are expected to achieve, and the public needs to be able to know whether they are meeting those targets.

In principle, the Ministry's annual service plan and subsequent reports on that plan, published each year as required by the *Budget Transparency and Accountability Act*, would be sufficient. In practice, versions of the service plan over the years have contained too few (and often changing) performance measures to be relied on for this purpose.

I believe that both the Ministry and the new authorities need greater clarity about the objectives they will be asked to achieve in "child safety and child wellbeing," to use the language of the *Child, Family and Community Service Act*.

Safety and wellbeing are complementary but not identical terms. Safety is about protection from abuse and neglect. Wellbeing is about a child's social, educational, and developmental progress.

In the area of child safety, there is a functioning data gathering and performance measurement system that will allow some precision in the framing of performance measures for the new authorities. The area of child wellbeing is less clearly defined, and not all of the relevant programs and services of government fall within the mandate of the Ministry of Children and Family Development.

To assess child wellbeing requires a sustained examination of such factors as rates of academic achievement, data on health status, and information from the justice system (to name some), among children in care as well as children in general. Here, progress has been uneven.

Current Initiatives

I am aware that the Ministry is engaged in a number of projects to establish measures of both safety and wellbeing and I applaud these initiatives:

- "Children Involved with the Ministry—Results.[16] " was recently posted on the Ministry website. It reports on a number of indicators including some outcome measures such as the rates at which Aboriginal families, and families generally, make repeated use of the child welfare system.
- The Federal/Provincial/Territorial Child Welfare Outcomes Initiative, designed to produce national information, has developed a draft set of child welfare outcome measures including recurrence of abuse or neglect, school performance, child wellbeing and permanence (duration of living arrangements). BC is involved, with other jurisdictions, in a two year pilot project.
- *Measuring Success: A Report on Family Outcomes in British Columbia* report was first published by the Ministry in 1997, and again in 1999 and 2002, with a 2003 addendum. It gives an overview of more than 100 indicators of health and wellbeing for all children, youth and families, to allow the Ministry "to assess the extent to which its programs, services and strategic approaches are making a difference at the provincial population level."[17] Unfortunately, this report contains scant information about children in care.
- The Ministry is collaborating with the Ministries of Health and Education to develop an integrated approach to measuring outcomes for children and youth who use programs of all three ministries. This initiative could be enhanced through linking data from these three ministries to create a more complete picture of the child or family, and of the impact of the ministries' actions and programs. (See Chapter 5 for a discussion of the use of linked data sets.)

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[16] www.mcf.gov.bc.ca/about_us/results.htm

[17] *Measuring Success: A Report on Family Outcomes in British Columbia*, 2001

- The Human Early Learning Partnership (HELP), at the University of British Columbia[18], has been tracking the development of BC's children for seven years, and is funded in part by the Ministry. This program could be consulted on the indicators and conditions that effect positive childhood development and on the development of data systems and linkage of information from multiple sources.

Using Data to Manage Performance

Over the past 10 years British Columbia has moved towards data systems that are more client-focused and now has a robust data gathering system, at least on par with any other province and well ahead of most. Still, there are gaps, and the Ministry recognizes that the rich amount of available data could be used more effectively. I understand that the Ministry is currently engaged in a process to further develop its data collection and evaluation systems to support both its ability to track and measure performance, and its management and operational decision-making.

The Ministry has made strong progress over the past several years measuring its activities and in improving its data collection and reporting. However, there is a gap at the provincial level, in the meaningful reporting of results; and at the regional level, in using the available data effectively to inform management decisions.

I understand that the Ministry is aware of the need to develop credible and useful measures of its performance and the need for better, more integrated management information and is working on both these areas.

These are some examples of performance measures that will be needed in the coming years:

- the average annual number of significant placement changes among children in care;
- the average number of days between entry into care and a permanent placement;
- the proportion of Aboriginal children in foster care who are placed with Aboriginal caregivers;
- the proportion of children in foster care and "kith and kin" placements who are "very satisfied" with their placements;
- the proportion of foster parents and kith and kin caregivers who are "very satisfied" with the support they receive from the Ministry or authority;

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[18] HELP has partnered with the Office for Children and Youth to examine the effect of taking children into care on their health, educational, criminal justice and income assistance outcomes.

- the proportion of children receiving child protection services who are at an age-appropriate grade level;
- the proportion of children in care who are taken into custody; and
- the rate at which Type II diabetes is found among children in care.

Many of these measures have recently been proposed by a Federal/Provincial/Territorial Outcomes Coordinating Committee on which British Columbia has been an active participant.

Recommendation 23

23

The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time.

Reason

Measurements that are based on actual results will give the Ministry and the public a better understanding of the children and young people in its care, and what effects its programs are having on their lives.

Recommendation 24

24

The Ministry should continue its work with other BC ministries to establish common measures and linked data sets.

Reason

Combining the information available from a variety of sources will give the Ministry and the public a richer understanding of the children and families being served and the impact on their lives of wide range of government programs and services.

Recommendation 25

25

Once collected and analyzed, data must be used as a tool to support operational and management decision making, and program evaluation and policy development.

Reason

When programs and policies are introduced, the Ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved.

Quality Assurance

Quality assurance is the means by which the Ministry ensures that it is complying with the laws that govern it and with its own standards and policies. Quality assurance activities also generate information that can be used to improve service delivery and practice.

Over the past two decades the Ministry's quality assurance program has included a range of activities and tools, such as:

- case reviews of critical injuries and deaths (which I discuss in some detail later in this chapter);
- audits of compliance with child protection practice and service standards (practice audits);
- standards for social worker qualification and training; and
- standards for obtaining delegation to assume duties under the *Child, Family and Community Services Act*.

I understand that following the Gove Inquiry, the Ministry made significant improvements to its quality assurance framework: it established a stand-alone quality assurance division; it enhanced the qualification and training requirements for entry-level social workers; it clarified and enhanced requirements for delegation under the *Act*; it developed standards, tools and methods to support case reviews being undertaken as required, and regularly scheduled compliance audits; and it monitored and tracked implementation of recommendations for improvements to practice that arise from case reviews and audits. (One flaw is that the Ministry does not do an aggregate analysis of recommendations from case reviews and practice audits, which would support systemic improvements to policy and practice.)

Then in April, 2003, the quality assurance function was effectively transferred to the regions as part of the move to decentralize authority for child protection and welfare services. I believe that with the transfer of this function to the regions, quality assurance within the Ministry has suffered. Practice audits were suspended during this time, until April 2004. Also, a significant backlog developed in the conduct of case reviews, though these are now complete. There were insufficient resources, both in the regions and at the Ministry's headquarters for an effective quality assurance function and little planning or regional staff training for the effective transfer of this responsibility. This happened because the Ministry drastically cut executive and support services in an attempt to protect front-line services during a time of severe budget constraints. The effect was that the centre lost its capacity and mandate to oversee, monitor and provide provincial direction to the quality assurance function.

I understand that these deficiencies have been recognized by the Ministry and that enhancement of the quality assurance function is now a priority. In June 2005, it significantly changed the June 2004 Quality Assurance Policy to enhance the quality of reviews and audits and development and implementation and tracking of recommendations. For example, the Regional Executive Director and Provincial Director now can add recommendations to those developed by the writer of a case review. The Ministry has recently increased resources to its quality assurance function at both the regional level and at the centre; is upgrading its tracking system for recommendations; and has begun to work towards an integrated quality assurance framework that will enhance its effectiveness.

Quality Assurance Needs Strengthening

The Ministry needs a strong quality assurance function to ensure compliance with its standards and practices, to evaluate internal performance against those standards, and to continuously improve systems and individual case practice, so that it can achieve better results for children, youth and their families.

A commitment to quality assurance based on regular measurements and audits, standards, and training, will be particularly critical as the Ministry continues to move toward greater decentralization. A strong commitment to quality assurance, coupled with sufficient resources, will promote consistency and standardization across the system and will allow us to understand how well each region is performing individually, and as part of the child welfare and child protection system in the province.

Recommendation 26

26

The Ministry must devote sufficient resources to develop and maintain a strong central quality assurance function at headquarters, in the regions, and in Aboriginal agencies. In consultation with the regions and Aboriginal agencies, headquarters must set provincial standards; provide training, support and expertise; and monitor results.

Reason

A strong quality assurance framework is essential for consistency and accountability and to promote continuous improvements to policies, standards and practice across the system.

Recommendation 27

27

The Ministry needs to develop its capacity to do aggregate analysis of recommendations from case reviews and regional practice audits.

Reason

Aggregate analysis of recommendations that come from case reviews and audits closes the quality assurance loop by promoting continuous improvement of policy, standards and practice.

Public Reporting

The history of public reporting on the Ministry's activities and performance, both by the Ministry itself and by external oversight bodies, has been inconsistent and uneven.

I discuss public reporting of reviews of children's critical injuries and deaths in Chapter 5, and reporting about the Ministry by the new Representative for Children and Youth in Chapters 2 and 5.

I believe that better, clearer, and more open reporting about its activities will generate better public understanding of the Ministry and the complexity of its programs. This will help to provide a context for serious issues that arise from time to time in tragic circumstances.

A decade ago, the Ministry did little in the way of formal, standardized reporting. There was no public information or reporting on performance measurement or quality assurance activities, and limited reporting through annual reports on the operations and programs of the Ministry.

After the Gove Inquiry, as part of their oversight functions, the Children's Commission and the Child, Youth and Family Advocate produced annual and special reports on their own activities and on various activities and programs of the Ministry[19]. The current Child and Youth Officer has responsibility for reporting about the child serving system and has produced general annual reports and special reports on a range of topics.

The Ministry publishes various reports on its website, and provides a link to the 2001 reports of the Provincial Health Officer on the health and mortality of children in care and the general BC child and youth population.

Still, reporting by the Ministry about its quality assurance activities remains scanty. For a time, practice audits were posted on the Ministry website (audits from 2000 to 2002 remain accessible, as are operational audits of Ministry programs and contracted service agencies for 1997 to 2004). However, the Ministry has not prepared an aggregate, analytical public report explaining and setting in context its quality assurance activities.

It did issue some press releases between 1996 and 2001, concerning high profile deaths or injuries of children involved with the Ministry: they generally acknowledged the incident; committed to further review of the matter; and indicated that the Coroner was investigating and the Children's Commission would also do a review.

Since 2002, only two Ministry case reviews have been publicly reported. I understand that those releases caused some concern in the Ministry's privacy and information branch. While the Ministry supports public accountability and transparency, it also has a responsibility to protect the confidentiality and privacy rights of the children, youth and families it serves and of the staff who provide the services. However, there needs to be a balancing of the scale towards more openness and transparency. I discuss these privacy issues in Chapter 5.

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[19] Children's Commission reports included annual reports on the roles and responsibilities and operations of the Commission; analysis of trends; reports on Ministry responses to recommendations; and special reports on fetal alcohol syndrome and on youth.

The Public Needs More and Better Information

Public reporting by the Ministry on its performance and on its quality assurance activities has been uneven and inadequate over the years. I believe that ineffective and insufficient public reporting has contributed to a public perception that the Ministry is not forthcoming, and perhaps even unwilling to reveal information about its practices and performance.

Furthermore, information the Ministry provides on its website is not as useful as it could be: child death statistics do not match other government reports; reports and statistics change from year to year; and some of the indicators and outcome results posted do not match the measures in the service plan.

Recommendation 28

28

The Ministry needs a regular, coordinated program of reporting on its activities and results achieved for children in care and children at risk.

Reason

The Ministry accomplishes a great deal and has many successes: if they are not reported on a regular basis, the public forms its impression of Ministry performance and operations on the basis of media reports of rare but tragic events.

Resolving Complaints

The two purposes of a complaints process (or dispute resolution process) are: first, to achieve the best result in the circumstances for a particular complainant; and second, to improve service in the future. Complaints resolution is a critical component of quality assurance.

The Gove Inquiry highlighted the need for a better dispute resolution process for children, parents and caregivers who are affected by administrative decisions about child welfare service delivery. It also recommended that each Ministry office (20 at that time) establish a process for receiving, investigating and responding to complaints, and that an independent, external complaint resolution function be established as well.

In 1997, the Ministry began building an internal complaint resolution process and the next year implemented a system, both at head office and in the regions, for tracking complaints, which has not been kept up to date because of reduction in quality assurance resources at head office. About the same time, the Children's Commission established its external complaint resolution process.

The Ministry's process begins informally, with discussions between the complainant and the social worker; if that doesn't resolve the matter, it goes to the social worker's supervisor, and then the manager. If there still is no resolution, it can be taken to a formal internal process, which means filing a written complaint with a regional complaint officer.

In the past, both the Child, Youth and Family Advocate and the Children's Commission were available to help a child or youth or family member with the process.

If a complaint could not be resolved through the Ministry's informal and formal processes, the Children's Commission could try to work with the Ministry to find a solution. If all else failed, the Commission would convene a tribunal to hold a hearing. The tribunal could not overturn a Ministry decision, but it could direct the Ministry reconsider its decision.

The core services review report of 2001 found that this progression of internal and external processes was not the most efficient or effective, and the Office for Children and Youth was not given a role in determining or recommending the resolution of individual disputes, as the Children's Commission had done.

Each region now has its own internal process, using recognized alternative dispute resolution tools such as mediation, but there is no standard provincial complaint policy[20] and no corporate monitoring of the results the regions are achieving in resolving complaints. Regions are at liberty to track information that meets their own purposes, and I believe they should have this flexibility, but there is no easy way to tell whether the system is operating consistently and effectively across the province, and there should be. All regions and Aboriginal delegated agencies should be required to report on standardized information, to allow for province-wide tracking and systemic analysis of information that comes from the resolution of individual complaints.

During the course of this review, I have heard concerns about the effectiveness of the Ministry's internal complaint resolution process and the lack of an external process and I have given a good deal of consideration to this matter.

It would be easy for me to recommend a return to the Children's Commission process but I don't believe that that would be a wise course. I have heard that the Commission's tribunal process became adversarial and legalistic in nature and tended to escalate conflict rather than resolve it. By the time the parties got to the tribunal stage, positions were pretty well entrenched all round, making it all the more difficult to find an acceptable resolution.

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[20] I understand that a dispute resolution policy has been drafted but has not yet been finalized.

On the other hand, the Ministry's performance in this area is, at best, inconsistent. The regions were left to develop their complaint resolution function at a time, as I have said earlier, of tumultuous change and budget reductions. These same factors also left the Ministry's head office with little or no capacity to support the regions in carrying out this role, so there has been little provincial oversight, monitoring, analysis and reporting.

We have to remember, when dealing with disagreements involving children, that children's lives go by very quickly, and a process that takes weeks to produce a permission slip for a field trip is beside the point, from the child's perspective. And if it takes months for a decision about a foster home move, the disruption in a child's life can be enormous.

Timeliness is important for another reason as well: it's usually the case that the sooner a disagreement can be addressed, the easier it will be to resolve. And if it can be dealt with by the original decision maker, without going "up the line" there is a better chance of a resolution that preserves the ongoing relationship between the child or family and the social worker who will continue to work with them.

Resolution processes involving Aboriginal children and families should respect cultural traditions. I encourage the Ministry to explore the potential for culturally based processes, perhaps taking advantage of the long house tradition in communities where that has long been a focus for community activity and healing.

I endorse the general principles articulated in the core services review report: that a complaints process should be accessible, simple, problem-solving rather than confrontational, marked by respectful and open communications, responsive to the complainant, and should involve the parties in resolving the issue.

I do not support the re-introduction of a separate external complaint process. A system that looks to resolving disagreements about services quickly and at the point where those services are delivered has the best chance of success. An internal process that embraces these goals, supported by the Representative in its advocacy role, taken together, provides the most effective complaint resolution process for those in need of this service.

To achieve that goal, the Ministry's internal complaint resolution process will need additional resources, both in the regions and at head office.

I believe the Ministry's draft policy is a solid foundation for an effective complaint resolution process, but it needs to be finalized and implemented. The Ministry, in consultation with the regions, must develop a set of standards and then monitor and audit the regions' performance. Then, the Ministry and regions should make use of the resulting information to help identify and address systemic problems in policy and practice.

In Chapter 2, I recommend establishment of a new external oversight body. This Representative for Children and Youth will have an expanded advocacy role directly focused on the child welfare system. It will have a regional presence, and will be able to help children, youth and their families to find their way through the child welfare system and make sure that if there is disagreement, they are able to make use of the Ministry's resolution process and that their voices are heard and considered.

Recommendation 29

29

That the Ministry finalize, with a new sense of urgency, its complaint resolution process, ensuring that the process is timely, accessible, and simple; that it takes a problem-solving, rather than confrontational approach; and that it is respectful and responsive to the complainant; and that it involves the parties in resolving the issue.

Reason

An effective internal complaints resolution process can lead to better results for the children and families who are served by the child welfare system and can also lead to continuous improvement of the system itself.

Recommendation 30

30

That the Ministry develop processes for resolving complaints by Aboriginal children, youth and families that incorporate and respect traditional cultural values and approaches to conflict resolution.

Reason

Aboriginal cultures have approaches to conflict resolution that involve families and communities and cultural traditions, which can lead to resolutions that preserve relationships and promote healing.

4.3 MINISTRY REVIEW OF CHILD INJURIES AND DEATHS

A History

The review of child injuries and deaths by a body external to the Ministry is a relatively recent phenomenon in British Columbia and resulted from recommendations from the Gove Inquiry in 1995. (In Chapter 2 I discuss this external review process.)

By contrast, the internal review by the Ministry of critical incidents involving children in its care has been a longstanding Ministry practice and a key element of its overall quality assurance framework.

Between 1986 and 1995, a unit in the Office of the Superintendent of Child Welfare was responsible for office audits and for Superintendent's reviews. These reviews were undertaken at the request of foster parents, family members, and other professionals. They could arise as a result of disagreement over case planning, or from the death or injury in suspicious or unusual circumstances of a child in care. There was a policy requiring that all such incidents be reported, but there was no formalized system and compliance was uneven.

In 1995, a new policy expanded and clarified reporting responsibilities. The policy on *Reportable Circumstances* required a formal report to be sent to the Superintendent on the death or critical injury of any child or youth who was in care or receiving Ministry services. (These are referred to as "reportable incidents.") The new policy also clarified the Superintendent's responsibility to respond to each report and do a review.

After the Gove Inquiry, the new Ministry for Children and Family Development made a number of changes to its internal critical injury and death review process. In 1996, it introduced the requirement for a Deputy Director's Review, which was a preliminary analysis of a report by field staff about the death or critical injury of a child. This preliminary review could lead to a further review by the Director (known as a Director's Case Review) if warranted. In high profile critical injuries or deaths, a Director's Case Review would be initiated immediately.

Between 1996 and 1998, Deputy Director's Reviews were completed for all reported deaths of children and youth who were in care or receiving Ministry services. In 1999 Deputy Director's Reviews were not done for most natural deaths, unless they raised questions related to practice.

Deputy Director's Reviews were done by practice analysts in the central quality assurance unit of the Ministry; Director's Case Reviews were generally done by contract reviewers.

During this period, all reports of critical incidents and all completed injury and death reviews were sent promptly to the Children's Commissioner. The 2001 core services review of the Children's Commission, Child, Youth and Family Advocate and other agencies, recommended significant change to the external child injury and death review process but supported the Ministry's internal case review process:

> *"To the extent that the goal of the review is improving the quality of service, the internal review is likely to be more effective that the external review. This is, in part, because those involved in the review, as insiders, will have a better grasp of the nuance of what is to be learned from the incident. They are also accountable, and therefore, have the responsibility to learn and make change".*

The core services review concluded that internal child injury and death review is an important part of the Ministry's self monitoring and contributes to its capacity to improve its practice. It recommended that the Ministry continue to review all reportable incidents. It further recommended that the Ministry be required, in the case of a death of child who was in care or who had received Ministry services, to do a full review of the Ministry services provided during the child's life: if policy or practice issues are raised, the Director would do a full review aimed at preventing similar situations.

On April 1, 2003, as part of the decentralization of child protection service delivery to the regions, the responsibility for internal child injury and death reviews was transferred to the regions along with responsibility for the other quality assurance functions.

I understand that insufficient resources were dedicated to support this new responsibility in the regions and a backlog of case reviews built up. In January of this year funding was directed to the regions to clear up the backlog and I understand that all outstanding reviews have now been complete.

The transfer to the regions of responsibility for case reviews also meant the loss of expertise in the conduct of these reviews that had been located at Ministry headquarters.

Enhancing Injury and Death Reviews

On February 15, 2006, Jane Morley completed a "Report to the Attorney General on the Director's Case Review Relating to the Nuu-chah-nulth Child Who Died in Port Alberni on September 4, 2002." That report, which was made public, included detailed recommendations for the Ministry's internal case review process.

I support many of the observations made in that report and endorse several of the specific recommendations. Following are my comments on areas where improvements could be made; where my views differ from the Officer's, this is noted.

Purpose of Injury and Death Reviews

This review has brought me to the belief that the primary purpose for reviewing injuries and deaths of children and youth who are in care or receiving Ministry services is to point the way to continuous improvements in policy and practice, so that future injuries or deaths can be prevented.

I recognize that not every injury or death is preventable, but it is important to take advantage of every opportunity to learn about possible improvements to policy and practice. The systematic review of deaths and injuries is one such opportunity.

A secondary purpose for reviewing children's injuries and deaths is one of public accountability. The death of a child who is in the care of the Ministry or receiving Ministry services is a rare but tragic event and the government has a responsibility to account to the public as to whether it has met its responsibilities to that child. The purpose is not to assign blame to individuals but to learn from mistakes and understand what went wrong and what went right.

Integrated Approach Is Needed

Each program area in the Ministry has its own policy and practice for reviewing injuries and deaths. This can be cumbersome when a child has been involved with different program areas such as child and youth mental health, youth justice, and others.

I understand that the Ministry is considering adopting a common review tool to guide the conduct of integrated reviews across program areas. I encourage the Ministry to continue these efforts and work toward a truly integrated internal child injury and death review process. This will result in recommendations that are more relevant to the way services are delivered in the regions and can contribute to improved policy and practice across all the programs that serve children, youth and their families.

During this review I learned that privacy laws can impose barriers to the conduct of an integrated review. I address some of these issues in Chapter 5.

Recommendation 31

31

That the Ministry adopt a common review tool to guide the conduct of cases reviews across all the program areas that are relevant to the life of a child who has died or been seriously injured.

Reason

Many children are served by several programs within the Ministry and only by looking at the role they all played in the child's life, can a true picture emerge. This broader view can form the basis for recommendations that will be more relevant and have more potential for prevention.

Timeliness

Under current policy, a Deputy Director's Review is to be completed within 90 days and a Director's Case Review (a more complete investigation), within eight months. These timeframes are rarely met. The reasons are many: insufficient resources, lack of personnel, and inexperience in the conduct of reviews all result in delayed completion times.

The Ministry should seriously consider adjusting its timelines to better reflect its capacity to complete its internal reviews while at the same time, meeting the need for timeliness. Once new timelines are established, they should be made public, in the interests of transparency.

Recommendation 32

32

The Ministry should adjust its timelines for its internal reviews, ensuring timeliness, but taking account of current capacity. Once established, the timelines should be made public.

Reason

Timelines that are routinely disregarded because they cannot reasonably be met do not encourage expeditious completion of these reviews. If reasonable timelines are established and published, the public can make realistic assessments of the Ministry's performance in completing its reviews.

Criteria for Undertaking Reviews

There is no clear direction to the regions as to when to undertake a review, and the level of review to be undertaken: that is, whether it should be a Deputy Director's Review or a Director's Case Review.

I support the Officer's recommendations that case reviews be expanded to cover deaths and critical injuries not only of children who are in care or receiving child welfare services, but also those who are receiving services from other Ministry programs, such as child and youth mental health, or youth justice. This goes to my earlier comment about the need for a more integrated approach to case reviews.

The Child and Youth Officer's report also suggests renaming the two levels of review. "Deputy Directors Review" and "Director's Case Review" are confusing. There should be two basic forms of review, clearly labelled: a file review, or a full review, which would include interviews with individuals who have relevant information. I support this simplification and rationalization.

The Officer's report recommends that the decision as to whether a review will be undertaken should take into account such factors as the seriousness of the result (in the case of injury); the connection between the incident and Ministry practice; and the potential for the Ministry to learn from the incident.

I suggest that the Ministry study this issue further and develop a set of criteria to guide managers in the exercise of their professional judgment and discretion in this area. For consideration, I propose the following criteria:

1. If a child is critically injured[21] or dies while in care, a review will be undertaken.

2. If a child is critically injured or dies:

a) while receiving Ministry services; or

b) having received Ministry services within the previous 12 months;

a review will be undertaken if the:

c) injury or death is, or may be, due to neglect or abuse;

d) injury or death occurs in unusual or suspicious circumstances;

e) injury or death is self inflicted, or inflicted by another person; or

f) Ministry's services, policies or practices may have contributed in some way to the injury or death.

Whether this is a file review or a full review will depend on the circumstances. I have suggested that reviews be undertaken in cases where there has been a relationship with the Ministry within the 12 months preceding the injury or death, but I suggest that there should be discretion to review deaths or injuries in cases where the relationship goes back further in time, if the circumstances warrant.

I am recommending that the death or critical injury of a child who is in care, regardless of the circumstances, always will require examination because the province is the child's guardian.

Just as caring parents would want answers to all their questions about a child's death or critical injury, so must the Ministry look closely to ensure that all questions are answered. In some cases, such as an expected death from the natural course of disease, this might be accomplished in a file review. Other cases will require much more.

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[21] A critical injury is one that may result in the child's death, or cause serious or permanent impairment to the child's health.

Recommendation 33

33

That the Ministry undertake reviews of critical injuries and deaths of children receiving services from any of its program areas.

Reason

A focus on all child welfare services will provide a more complete picture of the role that Ministry services play in child injuries and deaths.

Recommendation 34

34

That the Ministry rename its internal injury and death reviews and clarify the scope of each.

Reason

"Deputy Director Review" and "Director's Case Review" lead to confusion about the nature of each. Public accountability requires more clarity and simplicity.

Recommendation 35

35

The death or critical injury of a child who is in care should always be subject to a review, regardless of the circumstances.

Reason

The Province is the guardian of the child and has a duty to ensure that all questions about the child's injury or death are answered, just as a caring parent would.

Recommendation 36

36

The Ministry should develop clear criteria to guide the decision as to whether to review the death or critical injury of children who are receiving or have received Ministry services.

Reason

Guidelines will promote consistent approaches to reviews and ensure that time and energy are focused on those cases that have the potential to lead to better protection for other children in the future.

Recommendation 37

37

The Ministry should review injuries and deaths not only of children who were receiving Ministry services at the time of the incident, but also of children who had received Ministry services during the 12 months preceding, and in exceptional circumstances, going back even further.

Reason

There may be important lessons to be learned even from cases where the child, for some reason, was no longer receiving Ministry services.

Accountability and Responsibility for Review

Based on my understanding of the current lines of authority under the regionalized model, I believe that overall accountability for a review should rest with the Regional Executive Director in the region where the incident occurs. The Regional Executive Director should be responsible for deciding whether the established criteria have been met; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.

I expect that the Regional Executive Director will delegate the conduct of the review to the Regional Director of child welfare; or, if the Ministry moves to a truly integrated model, to the appropriate program director.

The Provincial Director of child welfare should retain the authority to conduct a review and in some high profile or exceptional cases, the review may well be conducted jointly, or may be led by the Provincial Director.

With respect to the role of the reviewer, it is my view that whether this person is an in-house practice analyst, or on contract, the reviewer is subject to the terms of reference and to direction from the Regional Executive Director, or the Provincial Director, depending on who leads the review.

The job of the reviewer is to objectively determine and analyze the facts for the Regional Executive Director, who has ultimate authority. In the end, the report is for the Regional Executive Director. However, in the coordinated and collaborative environment that I envision, the report and its recommendations would be developed in close consultation and collaboration with the Provincial Director, senior regional managers, and other senior program managers whose involvement is warranted in the particular case.

Regional practice analysts need orientation, training and mentoring. This, as well as the development of standards and maintenance of a list of qualified and competent reviewers, is appropriately a responsibility of provincial headquarters.

Recommendation 38

38

That the Regional Executive Director be responsible to decide whether a review should occur; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.

Reason

The Regional Executive Director has ultimate responsibility for the Ministry's activities in the region and so needs to be accountable for the review process.

Recommendation 39

39

That the Provincial Director of child welfare retain the authority to conduct a review.

Reason

The Provincial Director has province-wide responsibilities. In some high profile or exceptional cases, the review may well be conducted jointly, or may be led by the Provincial Director

Recommendation 40

40

That the Ministry provide required orientation, training and mentoring for practice analysts who will conduct reviews; and maintain a list of qualified reviewers.

Reason

This will support the regions and ensure a consistent quality of service across the province.

Consultation

I suggest that the Regional Executive Director consult as appropriate, with those who have experience and insights to contribute on a range of matters, including the decision whether to conduct a review, the scope of a review, the terms of reference, and the choice of person to conduct a review. This consultation should involve the Assistant Deputy Minister responsible for programs, the Provincial Director, and others, including an aboriginal delegated agency when appropriate. Consultation could also involve the contracted agency that provided service to the child or youth, or other involved professionals. I encourage the Ministry to clarify that the conduct of a case review is based on the principles of mutual trust, respect, and professionalism.

It is also imperative that there be clear assignment of roles and understanding of responsibilities.

I recommend that the ministry establish a multidisciplinary team to guide the review when needed and to participate in developing recommendations. The team could include representatives from other relevant Ministry programs, and from external bodies such as the Coroner, the police, emergency personnel, and medical professionals.

Recommendation 41

41

That the Ministry makes use of multidisciplinary teams in its child injury and death review process.

Reason

A team that brings together a broad spectrum of experience can contribute to a more thorough review and to the development of recommendations that speak to a wider range of services and public bodies.

Terms of Reference

Terms of reference are critical to the effectiveness of a case review. Without clearly defined and focused terms of reference, a review can quickly go off the rails.

The first step is to decide whether a file review; or full review is to be done. Then the scope needs to be defined: how far back in time will inquiries go; what individuals, if any, will be interviewed; and what range of services and programs, laws, policies, standards and practice are to be considered.

Considerable effort needs to be expended at the outset to avoid difficulties and wasted efforts later.

Developing Recommendations

Following the review, recommendations should be developed in collaboration with those responsible for the area being reviewed and the implementation of the recommendations. There is, as well, a strong role for headquarters in reviewing and contributing to the development of recommendations, because it can bring a broader perspective to the table. In turn, if headquarters is involved in developing recommendations from case reviews, that process can lead to improvements to provincial standards, policies and legislation.

Reporting

In Chapter 5 I discuss issues that arise in the reporting of reviews and make recommendations.

First Response Team

In addition to the improvements to the review process that I recommend, I propose that the Ministry consider the concept of a "First Response Team." Such a team could provide support to regions and delegated agencies when a child dies unexpectedly in horrific circumstances. The role of this team would be to provide increased capacity to the regional team where the death or critical injury occurred, assist in supporting ministry/delegated agency staff to ensure child safety for surviving/remaining siblings and family members, and also provide critical incident debriefing support to staff. I propose that this team be coordinated corporately by the ADM responsible for regional operations in concert with regional operations directors. This team should bring competency in crisis intervention, case management and coordination and understanding of the legislation and policies of all program areas.

Independent Oversight

Independent oversight is an important part of the Ministry's accountability framework. I discuss this and make recommendations in Chapter 2.

4.4 MODERN APPROACHES TO CHILD PROTECTION

Traditional approaches to child protection work, here and in many other countries, have leaned towards the use of court hearings and orders and removing children from their parents' homes if they were seen to be at risk there.

Yet we now know that children in care of the state fare less well than those in their own homes, even if those homes pose a degree of risk. The range of unwanted outcomes for children in care includes higher rates of illness, injury, and death by all causes, including suicide; a slower rate of academic progress, and a lower rate of high school graduation; and higher rates of incarceration and eventual dependence on income assistance. Research has confirmed that all these tendencies are true in British Columbia, some for many years. It is widely believed, and I believe as well, that we can do better.

The Ministry has responded to these research findings with an approach to protecting vulnerable children that is based on:

- Intervening early and working with families so that it may not be necessary to take children from home;
- Finding temporary homes with family or close friends, if children have to be removed for a time; and
- If children do need to be taken into care, planning for their care in a way that nurtures their family ties and ensures that they are not moved from place to place and that they have the opportunity to form life-long relationships.

The Ministry refers to this new approach as "service transformation." The intention is that it will be supported by regional networks of community based services. With the move to community governance–the Aboriginal and regional authorities the Ministry wishes to establish—planning for programs and services will be shifted closer to the children and families, so they will be better able to respond to individual needs.

Service transformation also means changes in the way that social workers do their jobs. Instead of formally investigating all reports of suspected abuse or neglect, they will assess them first and divert less serious reports to community agencies. Instead of placing children in contracted foster homes, they will look for the possibility of a temporary placement with family or close friends (kith and kin) while the home situation is stabilized. Instead of relying on court orders to resolve disputes, the service transformation model calls on social workers to use family case conferences, mediation, and other alternative dispute resolution processes wherever possible.

When children do have to be taken into the care of the Ministry, service transformation places greater emphasis on planning for these children so that they can have more permanency and stability in their lives, and not simply drift through foster homes until they reach age 19.

Introduction of the New Approach

Service transformation was introduced at a time of upheaval in the Ministry. I have described earlier the litany of changes that were taking place during 2002 and 2003. These programs were rolled out to the regions with little or no implementation planning and at a time of reduced budgets. I believe that this package of programs does have the potential to reduce costs over the long term, but there are upfront costs that must be met if the programs are going to have any opportunity of meeting their goals of better results for children, or even reducing the unwanted results that are still occurring.

It would be easy to underestimate the process of adjustment required of those who have worked, some for many years, in the old model. The move toward more out-of-care options and new dispute resolution processes requires a different set of skills and competencies from traditional child protection work. Social workers will be called on to mediate between family members in ways they never had to do before; to deal with new kinds of agreements; and actively monitor performance by contracted service providers for the life of the contract.

Another example of failure to support a program launch with the necessary upfront resources was the Ministry's campaign to recruit foster and adoptive parents. The intention was to support the new emphasis on permanency for children and supporting life-long relationships.

Unfortunately, it didn't dedicate the resources that were needed to respond to the level of interest that the campaign generated. This risks losing potential foster families and eroding public confidence in the organization.

I have learned about several initiatives that are planned for introduction over the next year and the Ministry seems to have recognized and understood the negative implications of introducing change without planning for implementation. One such initiative is additional support to foster parents. Foster parents are the backbone of a child serving system and this will provide much needed support.

I also heard about the importance of support from young people who have been in care, making the transition to adulthood at age 19. Formerly, there was support available for these young adults, just as parents will try to help their young adult children who are continuing with school or training. I trust that there will be support in the new budget allocations to allow for the return of this important program.

Better Results

I believe that, properly managed, these newer approaches to child protection work can result in better lives for vulnerable children and youth across the province.

But, I must also report that, in my interviews and in the public submissions I received, there were concerns about some of these new programs, including kith and kin agreements and youth agreements (agreements for at risk youth who can no longer live at home and are difficult to place in foster homes). I heard few calls for their elimination, but I do believe that all the programs within the service transformation initiative, beginning with kith and kin agreements, should be carefully studied by external evaluators to determine whether they are meeting their objectives.

An early evaluation can determine whether a program is being implemented in a way that is likely to realize its intended benefits. Then later evaluation can explore, in the light of the evidence, whether these benefits have actually been realized.

More generally, evaluations of new program initiatives should become a routine part of the Ministry's management, and should be undertaken in close consultation with the regions and with Aboriginal authorities once they become operational.

Recommendation 42

42

That government provide sufficient funding, staffing and training to support its newer approaches to child protection work.

Reason

If these programs are to achieve their intended results, of better outcomes for children, they need to be adequately funded at the beginning, even if they will eventually result in cost savings and staff have to be trained to use them appropriately and effectively.

Recommendation 43

43

That an external evaluation of all programs under the service transformation initiative, beginning with kith and kin agreements, be undertaken both during the implementation phase and then later, on an ongoing basis.

Reason

Early evaluation can determine whether a program is being implemented in a way that is likely to realize its intended benefits; later evaluation can identify potential for minimizing risk and improving outcomes.

Recommendation 44

44

That program evaluation become a routine part of the Ministry's management role, to be carried out in consultation with the regions and with Aboriginal authorities, once established.

Reason

Evaluation provides the information on which sound management decisions can be based.

Recommendation 45

45

That government provide training for current social workers and recruit individuals with the necessary meditation and counseling skills to support the service transformation initiative.

Reason

The service transformation initiative calls for a skill set not traditionally required of social workers.

Recommendation 46

46

That the Ministry reinvigorate its campaign to recruit foster and adoptive parents and ensure that it is funded so that it can to respond to public interest and participation.

Reason

The Ministry's past recruitment campaign generated a level of interest that couldn't be serviced by the resources available at the time: with adequate resources, many new foster and adoptive families might be found.

5

Communication and Coordination

COMMUNICATION AND COORDINATION

- ☐ Coordination
- ☐ Information Sharing

5. Communication and Coordination

5.1 COORDINATION

Governments are accustomed to doing a great deal of their work within the confines of single program areas, in single ministries, without regard to the activities of others, even other branches of the same ministry. This arrangement can produce efficiency and clear accountability, but the downside is that each program area becomes an organizational "silo," hunkered down and without a vision of the bigger picture.

On the other hand, child welfare is, in the vernacular of government, a "horizontal program." A horizontal program is one that needs cooperation and coordination among several program areas across ministries to achieve government's objectives. The management of horizontal programs has long posed a significant challenge to ministers and officials alike.

In British Columbia in the late 1970s, the ministries responsible for education, health, and social services tried to coordinate their planning and management for services to children with special needs through informal Children in Crisis Committees. These were replaced in 1979 by Inter-Ministry Children's Committees for hard to serve youth aged 12 to 19. In time, the Ombudsman reported that services for children and youth were still fragmented, and recommended a new authority to achieve better integration.

The answer was a Child and Youth Secretariat, involving Assistant Deputy Ministers of Social Services, Education, Attorney General, and Health. The Secretariat reported to a committee of Deputy Ministers. Some 12 regional and 120 local child and youth committees were formed to resolve local service delivery issues, review policy and planning issues, and report regularly to the Secretariat.

In 1994 the Ombudsman reviewed services for children and again found fragmentation and lack of accountability and integration.

Another way to deal with the complexities of horizontal programs is to bring them together within a single ministry. The Gove Report recommended this approach and in response, the Ministry for Children and Families was created in 1996, bringing together child protection and other child welfare programs, child and youth mental health services, youth justice programs, and programs for children with special needs.

I understand that not everyone in government who was affected was necessarily pleased to be part of this amalgamation, and that some of these tensions persist today. Collegiality and voluntary cooperation and information sharing do not automatically result from organizational redesigns.

But perhaps the larger issue facing the new Ministry was that it still did not contain all the pieces of the puzzle it was asked to solve. One of the key issues raised in this review has been the need, 10 years later, for better procedures for reporting and sharing information—especially about children in care of the Ministry—among Ministry social workers, delegated agency staff, police, medical practitioners, Coroner's staff, teachers and school counsellors, and other care professionals. This apparent reluctance to share needed information has some basis in law, as I discuss later in this chapter. But it may also reflect that many in the child serving system continue to work in "silos."

The importance of sharing of information and coordinating efforts was highlighted in reports by the former Children's Commissioner, and these same issues came to the fore at the recent inquest into the death of an Aboriginal child. The coroner's jury referred specifically to the need for greater understanding among emergency, police, Coroners Service and medical personnel of their obligations under section14 of the *Child, Family and Community Services Act* to report and record suspected abuse. The jury also recommended that relevant medical, pathology and autopsy information be shared with the social workers and others responsible for making care decisions. In this chapter I discuss information sharing and coordination in the context of reviewing injuries and deaths of children who are in care or known to the Ministry.

One of the promises of a more decentralized approach to program and service delivery for children is that, at the local level, good contacts and proximity will eventually produce a greater readiness to engage in joint operations, in pursuit of specific objectives set locally. In fact, it seems that already, the regions have achieved a greater degree of integration across program areas than has happened at headquarters.

During this review, I have heard suggestions of a need for regular meetings between public bodies that have child welfare functions, including the Ministry, the Child and Youth Officer, the Coroner, the Ombudsman and the Public Guardian and Trustee. Currently, these bodies have broad areas of mutual interest but have no forum in which to meet and discuss emerging issues relating to child protection and child welfare. I have also heard support for the use of more targeted task forces or working groups of staff from these various bodies to explore particular issues. Ongoing, informal contact between the Ministry and key oversight bodies was also suggested as an efficient way to provide the Ministry with the benefit of their experience and unique perspectives.

I heard further concerns about the need for cooperation and coordination between the Ministry of Children and Family Development and the ministries responsible for other services to children such as education, health, mental health and criminal justice. There are committees and forums to address specific issues, such as the Deputy Ministers' Committee on children and youth with special needs.[22] There is also the recently constituted (October, 2005) StrongStart BC, a Cabinet committee, and the StrongStart Deputy Ministers' Committee, which were created to support "a long-term strategy for putting children and families first." The StrongStart Deputy Ministers' Committee (which is a subcommittee of the Deputy Ministers' Committee on Social Development) is responsible for:

- developing a cross-government action plan for children, youth and families;
- proposing a set of clear measures and targets to assess results;
- recommending priorities and resource allocations; and
- ensuring collaboration and integrated approaches across ministries.

I understand that, to date, the focus has been on developing an early learning action plan to direct the use of federal funding provided through the 2005 Early Learning and Child Care agreement.[23]

However, there is no standing structure bringing together all government ministries and agencies involved in the child serving system to provide an opportunity to discuss common issues, develop comprehensive and integrated strategies, share experiences and identify how each ministry's work can complement the others. I recognize that amendments to information sharing and privacy legislation may be helpful or even necessary and I make recommendations for such changes later in this chapter.

I have also heard about the need for a broader data collection and analysis function that could lead to better understanding of issues relating to the overall safety, health and wellbeing of children. Several agencies currently provide this function to some degree, including the Coroner's Office, the Public Health Officer, the Child and Youth Health Branch, Ministry of Health, and the BC Injury Research and Prevention Unit.

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[22] This committee involves the ministries of Children and Family Development, Education and Health. There is also an inter-ministry committee to develop integrated performance measures for children and youth who are clients of programs of all three ministries

[23] With the change in government, federal funding under this agreement will be provided for only two years--2005/06 and 2006/07--rather than for the previously agreed five years.

The one specific recommendation I make below with respect to communication and coordination is not to suggest that this is the only way to improve channels of communication among various components of the Ministry and between the Ministry and other agencies. Throughout this report I have commented on the need for greater communication, consultation and coordination among those who play a role in the child welfare system. At the most basic level, better communication can start by simply picking up the phone or meeting one-on-one to discuss a case or issues of common interest. At a more systemic level, ad hoc working groups and committees can support communication and coordination.

I strongly urge every individual in the system to make every effort to find more and better ways to work together in the best interests of children.

Recommendation 47

47

That the Ministry establish a forum or council, including the new Representative for Children and Youth, the Coroners Service, the Ombudsman and the Public Guardian and Trustee, that will meet regularly to review developments and issues of common concern.

Reason

A forum that meets regularly will support communication and coordination between the Ministry and other bodies to ensure that developments and issues are brought to the forefront as they emerge, and will be a model for more collegial and collaborative approaches.

5.2 INFORMATION SHARING

During the course of this Review I have heard concerns for the protection of privacy that, in different settings and in different ways, restrict the flow of vital information within and among the agencies that comprise the child serving system. I had hoped to address these concerns, not all of which appear to be well grounded in law, in a few short pages. That turned out to be impossible.

In play is the interaction of the *Freedom of Information and Protection of Privacy Act*, with the *Child, Family and Community Service Act*, the *Adoption Act*, the *Coroners Act*, and others.

At some risk of oversimplification, I do believe that improvements can be made in the legislation that governs the collection, sharing, and disclosure of public information in the field of child welfare, and I will set out in these pages a summary of suggested steps in that direction.

Internal Case Reviews

At the time the *Child, Family, and Community Service Act* was drafted, the Ministry's approach to its internal child death reviews was not what it is today. Thus, the Act nowhere empowers the Director to collect the sensitive information needed to complete a child death review. Nor are staff of other agencies authorized to cooperate by sharing information, or to participate directly in these reviews. The Ministry has nevertheless conducted hundreds of internal reviews, all without statutory provision.

It is time to regularize this practice in law, and to authorize participation in the Ministry's internal review process by other agencies, including the police, Coroner's Service, doctors and other health care professionals, teachers, community workers, workers in the delegated Aboriginal agencies, and so on. It follows that those who participate in an internal review should receive, on a confidential basis, a complete copy of it.

Recommendation 48

48

That the *Child, Family and Community Service Act*, which sets out powers and duties of the provincial Director be amended to include the power to produce reports of internal child death reviews and to state that although the main purpose of the report is learning, public accountability is also a purpose.

Reason

This will clarify the Ministry's authority to conduct and publicly report on its case reviews

Recommendation 49

49

That the *Child, Family and Community Service Act* be amended to allow the Director to make information sharing agreements with other agencies for the purpose of multidisciplinary child death reviews.

Reason

This will allow other ministries, and other public bodies to fully participate with the Ministry in multidisciplinary child death reviews, with confidence that they have authority to share the information necessary for an effective and comprehensive review.

Recommendation 50

50

That the *Child, Family and Community Service Act* be amended to require the provincial Director to give, on a confidential basis, a complete copy of the final child death review report to all agencies that participated in a multi-disciplinary child death review team.

Reason

The multi-disciplinary review should also be a learning experience for the agencies that contribute to the death review, so it will be important for them to receive a full copy of the report.

The guiding spirit of the Ministry's internal child death reviews has been to improve case practice and thereby reduce the likelihood of future fatalities. It is not clear that the internal review process has paid dividends of this kind, not because of any failings in the reviews themselves, but because they were not always circulated within the Ministry to those who should take them to heart.

Further, in only three cases of which I am aware did the Ministry see fit to place an edited version of its internal reviews in the public domain for all to see. I believe that the Ministry needs to be much more forthcoming about its internal reviews, the recommendations that arise from them, and the actual implementation of these recommendations.

Recommendation 51

51

That in its annual reports, the Ministry of Children and Family Development provide a statistical report of its reviews of deaths and critical incidents, as well as the recommendations that resulted from those reviews, and a progress report on their implementation.

Reason

Statistical reports (without personal information) allow the public to become aware of developing trends. Reports of recommendations and their implementation will show the extent to which the lessons contained in the case reviews are being reflected in Ministry policy, procedures and practice.

Recommendation 52

52

That twice a year the Ministry of Children and Family Development publicly release a summary of each child death review it has completed during the previous six months. The summaries would contain no names, dates or places.

Reason

By reporting on groups of cases periodically (ideally, every six months), without identifying details, the Ministry can account to the public without undue delay, while protecting the privacy of children and families.

Further, in high profile cases where information that would otherwise be restricted has already been lawfully disclosed to the public, the Ministry needs to be able to account publicly for its actions. The identity of the child and the results of the Ministry's own internal review should be reported promptly if this can be accomplished without an unreasonable invasion of privacy. I recognize that, if a criminal proceeding is contemplated, some delay in the release of information may be justifiable.

Recommendation 53

53

If the death of a child who was in care or known to the Ministry has already been disclosed by police, a court or the Coroner, the Ministry should be permitted by the *Child, Family and Community Service Act* to disclose the child's name and relationship to the Ministry and the contents of the Ministry's case review, to the extent necessary for accountability but without unreasonable invasion of privacy.

Reason

In high profile cases where information has been lawfully disclosed to the public, the Ministry needs to be publicly accountable for its actions. Because the provision would be permissive and not obligatory, the Ministry could decline to make any disclosure that could interfere with a criminal proceeding.

New Representative for Children and Youth

The new Representative for Children and Youth should receive from the Director, a copy of every internal child death review and critical injury review completed by the Ministry. More generally, the work of the Representative will require it to delve into the operations of other ministries and agencies on a routine basis.

It is vital that the authority of the Representative to receive sensitive information from these other bodies be plainly set out in law, consistent with the provisions of the *Freedom of Information and Protection of Privacy Act*.

I suggest that the Representative for Children and Youth be given the same authority to collect information as is given to the Office for Children and Youth by s.11 of the *Office of Children and Youth Act*: the Officer has the right to obtain from public bodies information that is necessary to enable for the performance of the duties and functions of the office. It should also provide that these records will be provided promptly and without charge.

The Representative will play an important public accountability role in reporting on the child welfare system. The office needs authority to publicly disclose personal information in limited circumstances.

Recommendation 54

54

That the *Representative for Children and Youth Act* contain an authority to collect information that is at least equivalent to s.11 of the *Office of Children and Youth Act*; provisions to ensure that the records it requests are delivered promptly and without charge to the Representative; and to permit public disclosure of personal information if it is in the public interest, necessary to support the findings and recommendations, and not an unreasonable invasion of privacy.

Reason

The Representative needs to have clear authority to obtain from other public bodies, who are subject to the *Freedom of Information and Privacy Act*, the information necessary to do the work required of the office. This information should be provided without charge because it is being used to further common goals—the safety and wellbeing of children and youth. It also needs the authority to report personal information, in limited circumstances, to fulfill its role in public accountability.

Data Linkages

There is enormous promise, and a bit of danger, in the use of linked administrative data files to both sharpen and broaden our understanding of what is happening to the children in our care. Linkages can be made between sets of data to examine, for example, use of hospitals and medical services by children known to the Ministry of Children and Family Development or in its care. Ministry data can be linked with records from schools, showing educational progress of children in care from year to year. Linkage might be made to the youth justice system or, later, to income assistance files. Improved public reporting on these sorts of results could be expected as a result of increased data linkages.

Data linkages could make it easier for the Ministry and the Representative to understand what impact children and families are experiencing as a result of the Ministry's increased use of out-of-care options such as kith-and-kin agreements.

Currently, decisions about whether to use these options are being made every day without much guidance on the real-world impact they are having.

The danger of enhanced data linkages is that it could lead to an Orwellian scenario in which government knows too much about our children and us. This is an understandable fear, but one that can be addressed. Researchers may need to know a lot about individual cases, but they will rarely need to know the identity of any of them. The use of a unique statistical identifier to preserve anonymity has a long history in the federal government and some history in British Columbia as well. In short, well known procedures and careful legislative drafting can attend to the dangers of intrusiveness in the way that they already have in s.9 of the *Ombudsman Act* and when the mission of the Child and Youth Officer was framed.

Indeed, I am impressed with the work of the Child and Youth Officer on data linkages, and would like to see this work advance in the coming years. Better research can lead to better programs and services. There should be no question about the statutory foundation for this activity in the Ministry or the Representative for Children and Youth. In turn, these bodies should provide assurances that all identifying information is removed from their public reports and that the highest privacy standards are met.

Recommendation 55

55

That the *Representative for Children and Youth Act* clearly provide for the creation, use and disclosure of linked data sets for purposes specified in the *Act*.

Reason

The Representative needs to collect and link data about children so that it can monitor and evaluate the effectiveness, responsiveness and relevance of services provided to children, youth and families.

The Representative needs to disclose data—with personal information removed—to researchers so that they can assist the Representative in its monitoring role.

The Representative needs to publicly report statistical data to fulfill its role of ensuring public accountability of the child welfare system.

Recommendation 56

56

That the Representative, in collecting linked data from the Ministry of Children and Family Development and other public bodies for the purpose of fulfilling its monitoring role, develop policies and practices to ensure that all identifying information is removed from public reports and that the highest privacy standards are met.

Reason

Linked data sets contain personal information from various sources, linked to identification of an individual and so are highly invasive of privacy. Therefore, they need to be used with great care and only when necessary for the benefit of the individual.

Recommendation 57

57

That the Ministry of Children and Family Development, in collecting linked data from other public bodies for the purpose of decision making about individuals, ensure that the absolute minimum information is collected and that each linking is necessary to enable the Director to deliver mandated services, and that the highest privacy standards are met.

Reason

Linked data sets contain personal information from various sources, linked to identification of an individual and so are highly invasive of privacy. Therefore, they need to be used with great care and only when necessary for the benefit of the individual.

Recommendation 58

58

That the *Representative for Children and Youth Act* contain a provision similar to s.9 of the *Ombudsman Act*, requiring that information collected by the Representative be kept in confidence, with a limited right of disclosure.

Reason

The Representative will be collecting highly sensitive personal information, including linked data. A confidentiality provision will ensure that personal information will only be disclosed in accordance with the statute.

Partner Ministries

The Ministry already has authority to collect data about children from the Ministries of Health, Education, and others, and to use that data in the way that a parent might use information to make decisions about individual children. The authority is contained in s.96 of the *Child, Family and Community Service Act*. However, I understand that currently, the Ministry uses research agreements under section 35 of the *Freedom of Information and Protection of Privacy Act* to receive data from its partner ministries. This provision is designed for research purposes and does not allow data to be used for making decisions about individual children. This anomaly should be rectified.

Recommendation 59

59

That the Ministry of Children and Family Development should not rely on research agreements to collect and link personal information from other ministries and public bodies: it has the authority under *Child, Family and Community Service Act* s.96 to collect information and to use it to make decisions about individual children.

Reason

The Ministry should use the authority it has to gather data about children from Ministries of Health, Education, and others, and use it the way a parent would, to make decisions about individual children.

The Ministry needs to ensure that no legislative or operational barriers remain to block the sharing of information across its program areas. Further, the confusing array of authorities now facing busy Ministry workers should be greatly simplified and issued in a single, comprehensible reference text which should be updated from time to time.

Officials in other agencies working alongside the Ministry are perhaps even more disadvantaged by the differing provisions of the relevant statutes prescribing how and under what conditions sensitive information can be shared.

This has contributed to a culture of secrecy so that information that is vital to securing a child's best interests is sometimes withheld from Ministry staff.

I understand that amendments to the *Child, Family and Community Service Act* came into force in January, 2006, to bring the *Act* into line with the counterpart provisions of the *Freedom of Information and Protection of Privacy Act*. I trust this will go some way towards alleviating the culture of secrecy that has developed.

Recommendation 60

60

That the Ministry of Children and Family Development review the statutes that govern it to ensure that there are no statutory barriers to disclosure of information among program areas.

Reason

Many children are served by more than one program within the Ministry of Children and Family Development and their best interests often require that personal information about them be shared between programs. Ministry staff should be confident that they have the authority to share that information.

Recommendation 61

61

That the Ministry of Children and Family Development review its privacy policy documents to ensure that they are current, accurate and easily useable by employees.

Reason

Policy documents that are intended to guide employees need to be current and presented in a way that is easily useable by busy workers.

Disclosure of Personal Information

Section 33 of the *Freedom of Information and Privacy Act* contains the rules for disclosure of personal information by a public body. In effect, this section creates two sets of rules and which one applies, depends on whether or not there has been a formal *Freedom of Information* request. If the same "unreasonable invasion of privacy test" were to apply whether or not there had been a formal request, both the Ministry and the Representative would be free to make an assessment of what information ought to be disclosed in particular circumstances, to meet the need for public accountability while protecting personal privacy as appropriate.

Recommendation 62

62

That the *Freedom of Information and Protection of Privacy Act* be amended to incorporate the "unreasonable invasion of privacy" test into s. 33.2, which authorizes public disclosure of personal information under certain conditions.

Reason

This would allow a public body to balance the need for public accountability with privacy interests in a way that is appropriate to the circumstances, by allowing a public body to disclose proactively the same information that could be disclosed in response to a formal access request.

6

Failed Transfer of Files and Function

FAILED TRANSFER OF FILES AND FUNCTION

- ☐ Transfer of the Child Death Review Function
- ☐ Transfer of the Death Review Files to the Coroner

6. Failed Transfer of Files and Function

6.1 TRANSFER OF THE CHILD DEATH REVIEW FUNCTION

In response to a request by the Solicitor General[24] I agreed to examine the process by which the child death review was transferred from the Children's Commission to the Coroners Service. The Deputy Minister in the Ministry of Solicitor General had begun an investigation, interviewing key individuals and reviewing relevant files and databases. Those materials were turned over to me, with a request that I complete the investigation and make recommendations for avoiding such problems in the future.

I caution that my findings and conclusions are based on the information I was provided by the Solicitor General, on my interviews with many of the people who were involved in the transition, and on submissions I received. There may be cabinet documents or other information, of which I am not aware, that would support another view.

The Team

The transition steering committee was chaired by the then Deputy Attorney General and included heads or senior representatives from the Public Guardian and Trustee, Ministry of Children and Families, the Ombudsman, Child and Youth Advocate, Children's Commission and Chief Coroner. Available minutes indicate that the committee met in twice, in February and March, 2002. It may have met once or twice more.

The Transition Plan

The core services review recommended that the Coroners Service assume some elements of the Children's Commission's role in child death reviews. Specifically, the Coroner would review those deaths in which the provision of government or medical services during the child's life had contributed in any way. There was also a recommendation that the Coroner would convene a multidisciplinary team to review all unexpected, unforeseen and unexplained deaths of children and make recommendations to government and other public bodies.
Building on the database developed by the Children's Commission, the Coroner would work with the Vital Statistics Agency to collect comprehensive data.

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[24] See correspondence at Appendix C.

The account that has been provided to me of the meetings, correspondence and discussions that took place during the transition period reflect a lack of clarity around the scope of the responsibilities that were actually being transferred to the Coroner.

It is a widely held view that it is more productive to emphasize the collection and analysis of statistical information about injuries and deaths, and to more narrowly define the range of individual deaths and injuries to be reviewed. Clearly this was the view of the Chief Coroner. I understand, from frequent references in the documents I was given, that there was general understanding that the Coroner was to have considerable discretion in defining the scope of his responsibilities, particularly with respect to the files being transferred from the Children's Commission.

The recommendation of the core services review was that the Ministry would continue to do its own reviews where the child had been in care or receiving Ministry services.

The new Officer for Children and Youth would collect and monitor statistical information on child deaths and would conduct further investigations based on that monitoring[25].

When the transition team was put in place in February, 2002, one of the issues identified in its terms of reference was: "Ensure that a plan is in place to move the fatality review function to Office of the Chief Coroner."

It now appears that such a plan was never fully developed or implemented, nor was there a clear consensus as to exactly what "fatality review function" was being transferred to the Coroner.

The Transition Process

The *Office for Children and Youth Act* was introduced in May, 2002, but not yet proclaimed.

By this time, the Children's Commission had stopped opening new files and was concentrating on concluding active investigations. However, to support the transition, the Commission did continue to enter into its database the information it received from Vital Statistics about every child death.

In June, the Children's Commission wrapped up its work on child death reviews by reporting on its final 108 completed reviews.

During the summer of 2002, the Coroner and the Children's Commissioner—who was to become the acting Child and Youth Officer on proclamation of the Act—and members of their respective staffs were meeting to discuss the transition but there was no agreement yet on the allocation of responsibilities between the new Child and Youth Officer and the Coroner.

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[25] The *Office for Children and Youth Act*, s. 3 (2) authorizes the Officer to monitor the delivery of services in relation to the requirements of the *Child, Family and Community Service Act*.

Resource Issues

Well before the transition, the Coroner was already struggling to carry out its statutory mandate to investigate unexpected and unexplained deaths. On July 18, 2002, the Chief Coroner wrote to the Ministry of Solicitor General, confirming his understanding that on proclamation of the new *Act* the Coroner would become the final reviewing agency for child deaths in BC, and that to fulfill this new role he would need an additional $415,000. A Ministry official forwarded the proposal to the Deputy Solicitor General, saying that it was a reasonable amount, but that the allocation of responsibilities between the Coroner and the Office for Children and Youth was still under discussion at that time.

The Coroners Service is a small program and budget in the context of the Ministry of Public Safety and Solicitor General. While it is independent from government in its statutory role, for financial and administrative purposes it reported to an Assistant Deputy Minister[26] who was responsible for a number of larger programs and services, and this was at a time when all ministries were looking for ways to trim their budgets further.

Although $200,000 and two staff positions were transferred from the Office of Children and Youth to the Coroners Service to support the expanded child death review function, it wasn't enough.

The Coroners Service considered using the database that had been developed by the Children's Commission's but it was tailored to children's deaths and the Coroner needed a system that would collect information on all deaths, and that would link to the national database death information system. The Coroners Service decided to develop a system that better met its needs: unfortunately the new system didn't become operational until early March, 2006.

The New Act

On September 30, 2002, the new Office for Children and Youth Act was proclaimed, with the former Children's Commissioner as the acting Officer for Children and Youth.

As of that date, the Commission's authority was repealed and the new Act required that it transfer to the Coroner all records relating to its investigations of child deaths. The Coroner was authorized—but not required—to continue any investigation into a child's death that had been begun by the Commission.

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[26] This was changed in November, 2005, and the Chief Coroner now reports to the Deputy Minister.

In fact, at that time the Coroner's office did not receive any child death files from the Children's Commission. Despite the July letter that referred to the date of proclamation of the statute as the "handover" date, the Coroners Service operated under the assumption that it would not take on its child death review responsibilities until January 1, 2003. (In discussions with the Children's Commission, Coroner's staff had been told that the Commission had made a mistake, when it began operations, by going back in time to deal with deaths that had occurred earlier and it had never fully caught up. The Coroner, exercising the discretion he was given, decided to pick a date, which was January 1, 2003, and move forward from there.)

Later in this chapter I discuss what happened to the Children's Commission's child death review files at that time.

Discussions continued among the acting Child and Youth Officer, Ministry of Attorney General, Ministry of Solicitor General, and the Coroner about roles and responsibilities, sharing information, transferring files, and integration of databases.

The new Child and Youth Officer was appointed, effective May 1, 2003. It did not begin receiving reports of child deaths and critical injuries from the Ministry until March, 2005.

The Coroner was working to recruit a qualified individual to head up its new Child Death Review Unit but it was not until May, 2003 that a manager was appointed and began to put in place a process, within the confines of existing budget and staffing limitations. That individual was only in the position a short time when he had to be reassigned to fill an unexpected vacancy; a new manager was appointed but lasted only a few months. A third manager took on the role in June, 2004.

Legislative changes were identified in mid-2003 as necessary for the Coroner's new role, and to ensure confidentiality of information shared with the planned multidisciplinary team. Drafting began last fall but was suspended pending the completion of my review.

Investigating the Transition

In November, 2005, there was growing public criticism of the Ministry's internal review of the death of an Aboriginal child, who had been placed in a "kith and kin" arrangement by a delegated aboriginal agency.

Soon there were reports of hundreds of outstanding reviews and the Premier admitted that there clearly had been a problem. He was quoted, however, as saying that the transition plan "was pretty clearly laid out in the legislation" and that the problem was not a result of budget cuts. Subsequently he acknowledged that there had been a breakdown of the transition process and, in accepting responsibility for what had occurred, he expressed his unhappiness and that of his Cabinet colleagues.

As noted earlier, I had already been appointed to look at the system for reviewing child deaths and the Solicitor General then asked me to complete an investigation of the transition process that had been begun by his Deputy.

In a letter to me dated December 14, 2005[27], the Solicitor General said there had been a "complete failure of the transition process." He identified three factors that had contributed to that failure:

> *"First, while a team was established to oversee the transition, the subsequent planning and implementation was inadequate. Transition planning was complicated by the involvement of multiple agencies, unclear roles and accountabilities, and a lack of follow-up as responsibilities shifted from one agency to another.*
>
> *"Second, there is clear evidence that budget constraints were a complicating factor in the transition. The Children's Commission and Office of the Child Youth Advocate were wound down at the same time that reduced resources were made available to the Coroners Office to undertake child death review functions. These constraints, along with the adoption of a new approach to child death reviews resulted in a decision not to proceed with a second stage review of files transferred from the Children's Commission.*
>
> *"Third, there were inadequate data-record and reporting systems. Each of the Children's Commission, the Coroners Service, the Office of the Child and Youth Officer, and the Ministry of Children and Family Development use unique electronic systems that do not communicate or share information with each other. As such, each agency operates in some isolation from the others, leading to potential inconsistent approaches on specific cases and inevitable duplication of efforts."*

The letter was released publicly and was followed by media reports that the Solicitor General had spoken to the effect that although he had not named people who might be held responsible for the failings outlined, I could do that, and it would be left for me to say whether somebody should pay the price politically, or should resign. In light of those comments, I sought legal advice about the scope of my authority. I was advised that my terms of reference do not include making findings of fault against individuals.

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[27] The letter is attached in Appendix C to this report.

I communicated this to the Solicitor General by letter of January 6, 2006[28]. He replied January 31[29] but to avoid any possible misunderstanding, I confirmed my view as to the scope of my mandate by letter on February 10, 2006[30].

My Conclusions

I agree in every respect with the comment of the Solicitor General quoted above.

I cannot agree with the Premier's earlier assessment that budget cuts did not contribute to the failure of the transition process, or that the transition provisions of the new Act constituted a clear plan for the transfer of the death review function. As I have commented throughout this report, the impact of budget constraints reverberated throughout the child welfare system from 2002 until recently. Those responsible for the transition were under pressure to meet deep spending cuts across the board and as a result, this small program got lost in the shuffle.

Time to Move On

I base my conclusions on this and on all the matters I address in this report on the material that was collected and provided to me by the Deputy Solicitor General, on the interviews I conducted, and on the many submissions I received. Because of my conclusion about the limits of my authority I did not ask for further information or documents from the relevant ministries or other public bodies.

It is certainly possible that something more might be learned from a more extensive investigation. My view is that now is the time for government to move forward and not spend more time and money looking backwards. In the next chapter I set out my recommendations for a successful transition from the current system to the one I propose. This is a model for an effective and professional transition that should avoid the many pitfalls that occurred in the past.

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[28] The letter is attached in Appendix C to this report.
[29] The letter is attached in Appendix C to this report.
[30] The letter is attached in Appendix C to this report.

6.2 TRANSFER OF THE DEATH REVIEW FILES TO THE CORONER

Once government had announced its adoption of the core services review recommendations in February, 2002, the Children's Commission decided not to open any new child death review files for investigation, but to complete the many investigations that were currently underway. In June, 2002, the Commission issued its last report, noting that it had publicly reported on 769 child death reviews over the course of the six years of its operation.

The last file to be opened by the Children's Commission was on January 19, 2002, but the Commission (and subsequently, the Office of Children and Youth) did continue to record all child deaths in its database, though paper files were not opened and investigators were not assigned.

Our examination of the Children's Commission's database confirmed that:

- 539 files were active at the time the office closed; and
- 244 child deaths were recorded by the Children's Commission (with no paper file opened) between January 19, 2002 and September 30, 2002, when the Commission closed and responsibility transferred to the Coroners Service;
- 172 child deaths were recorded by the Office for Children and Youth in the Children's Commission's database between October 1, 2002 and March 21, 2003, when the final entry was made.
- I refer to these 955 files as the "transition files."

Of the 955 deaths, 29 were identified by the Commission as being "in care." My review learned that the Commission did not verify the child's legal status until the review or investigation was nearly completed and that number turned out to be incorrect: in fact, 22 were in care; five had received Ministry services, and two were not known to the Ministry at all.

The former Children's Commission, the Coroners Service, the Vital Statistics Agency, and the Ministry of Children and Family Development all use the International Classification of Disease standard for describing the cause of death:.

- **Natural:** any death that is not the result of an external injury
- **Accidental:** any death resulting from an external injury that is considered unintentional
- **Suicide:** any death due to self-induced external injury
- **Homicide:** any death due to an external injury intentionally caused by some else other than the deceased, and
- **Undetermined:** any death for which the cause is unknown

The table below shows the causes of death among the 955 transition files. It also shows the causes of death among the 22 of those children who were in care at the time of their deaths, and the 233 who had been receiving Ministry services either at the time of death, or during the previous 12 months.

Figure 2: Transition files, classified by cause of death

Cause of Death	Transition files	Children in care at time of death	Children who had received Ministry Services within the year
Natural	383	11	114
Accidental	311	1	44
Suicide	69	6	24
Homicide	41	0	19
Undetermined	64	4	20
Total deaths classified	**868**	**22**	**221**
Not yet classified	55		4
Insufficient information	32		8
Total	**955**	**22**	**233**

The group of 955 transition files cannot be considered a representative sample. The files span a timeframe of approximately 6½ years but a number of these deaths occurred more than eight years ago and investigations remained incomplete.

This suggests that these deaths may have presented more complex issues, or that police or Coroner investigations or court proceedings, may have delayed closing of the file, or there may have been some other reason, unknown to me.

Most child deaths are the result of natural causes and the large majority of those occur before the age of four. The next leading cause of death among children and young people is accidents, and the leading cause of accidental death is motor vehicle accidents. Too many of our youth are losing their lives, as passengers or drivers of vehicles where speed, alcohol and failure to use seat belts are contributing factors. This is an area, I believe, that requires greater attention by our public policy makers and agencies such as ICBC, law enforcement and prosecutors, to name a few.

Location of the Transition Files

Of the Children's Commission's 539 active investigation files 466 were sent to off-site storage in Victoria by the Office for Children and Youth in March, 2003, and 73 were inadvertently left in the Children and Youth Office. The Coroners Service did not believe it would need access to the 539 files: it had simultaneously been receiving information on these same child deaths from the Vital Statistics Agency, police reports, medical certificates, and from the Ministry.

The 416 database records for which paper files had not been opened remained at the Office for Children and Youth. However, the Coroners Service continued to have access to these records.

In early December, 2005, the Information and Privacy Branch of the Ministry of Attorney General and Ministry of Public Safety and Solicitor General identified all of the transition files and retrieved them, to inspect and account for each one. The names of all files were accounted for, including 56 files that had been retrieved from off-site storage by the Coroners Service in September, 2005.

The 73 Children's Commission files that were inadvertently left at the Office for Children and Youth, were located at that office in November, 2005, and were also accounted for by the Information and Privacy Branch and forwarded to the Coroners Service.

Before the Commission closed, the parents and caregivers of 79 children and youth whose deaths were being investigated, had notified the Commission that they wanted to receive a copy of the completed report. The Commission had written to these parents to tell them that the Commission was closing, the investigation of their child's death was incomplete, and the file was being transferred to the Coroners Service. It is unclear from the information I have been given whether these parents were told that the Coroners Service would be assuming responsibility for the investigation.

In January, 2006 the Coroners Service wrote to the parents and caregivers of those 79 children and told them that the Coroner's report on their child's death was complete and if they wished a copy, they were to contact the Coroners Service. To date, eight families have asked for a copy of the Coroner's report (judgment of inquiry). Twenty letters have been returned with no forwarding address. The Coroners Service will continue trying to locate these families.

In eight of the transition files, the Commission investigation reports actually had been completed. Pursuant to the *Office of Children and Youth Act*, these reports are in the possession of the Child and Youth Officer who will determine whether and how they might be released.

In total, the 955 "transition files" have been located, examined and are now with the Coroners Service in Burnaby.

Coroner's Investigation of the Transition Files

With its new child death review function, beginning in January, 2003, the Coroners Service began to look at all child deaths, including natural deaths. The Coroner now receives notifications from Vital Statistics of all deaths. In the case of natural deaths, the Coroner examines the medical certificate and in about 10% of those cases, decides to investigate further.

It is important to understand the difference between the Coroner's traditional role in *investigation*, and the new *review* responsibilities that were being assumed. Under the *Coroners Act*, the Coroner investigates all unexpected, unattended and unexplained deaths, whether adult or child, to determine who died, and how, when, where and by what means the death occurred.

The child death review function is described in Chapter 2, but briefly, it is a search for lessons that may help us to keep other children safe. A coroner's investigation would be one contribution to a child death review.

A Coroner's investigation normally results in a report called a judgment of inquiry. To date, coroners' judgments of inquiry have been completed on 627 of the 955 child deaths.

The Coroner holds a public inquest if there is no other way to obtain necessary evidence; if the evidence is contradictory and a hearing is needed to sort out the facts; if there is a need to bring the public's attention to a prevention issue that has gone unheeded; or if a case has been the subject of public attention and a public hearing is considered the best way to satisfy the public's need to understand.

Between 2003 and 2005, three of the 955 children's deaths have been the subject of an inquest and a fourth is scheduled for inquest in April, 2006. Two more will be scheduled in the near future.

Coroner's Child Death Reviews

The Coroner's Child Death Review Unit was put in place to carry out the Coroner's new child death review function. As a result of direction from the Solicitor General in November, 2005, the Unit began to review all 955 transition files.

The Coroners Service does not view itself as, nor was it intended to be, an oversight body for the child welfare system.

Medical Coroner Review of Natural Deaths

A medical coroner is reviewing all natural child deaths among the 955 transition files, to determine whether further investigation is required. Of the natural deaths reviewed so far, two natural deaths and 26 accidental deaths (which were previously classified as natural), have been re-opened for further investigation.

Coroner's Quality Assurance Review

The manager of the Child Death Review Unit undertakes a quality assurance review of all investigations and judgments of inquiry. This review is to ensure that all investigative policies, protocols and procedures are met.

The manager reviews all recommendations arising out of a coroner's death investigation after they have been approved by the Regional Coroner and Chief Coroner, and identifies any others that should be made to prevent further similar deaths.

The manager holds internal multidisciplinary team meetings to review trends and specific deaths and to make recommendations. The Coroners Service has not established an external multidisciplinary team due to the legislative impediments mentioned earlier. Neither has there been a protocol established between the Office of Children and Youth and the Coroners Service to ensure regular coordination of investigations of deaths of children who had been in care or receiving Ministry services.

Coroner's Child Death Review Protocol

A comprehensive 14-page data collection form, referred to as a "child death review protocol" was developed by the Child Death Review Unit and is completed for each file investigated or reviewed.

The protocol collects detailed information about the child, the child's family, and the child's connections, if any, to the Ministry, as well as extensive information about the death and investigation.

Aggregation and Analysis of Data

The Coroner is recording information about the 955 children's deaths and will aggregate and analyze the data to identify trends and patterns that will form the basis for future public reports.

In addition, the Coroners Service has done a retrospective review of *all* child and youth deaths since 2002, using the new child death review protocol. This information will also support future trend and pattern analysis and promote public awareness of health and safety issues.

The table below shows the status of the Coroner's handling of the transition files as of November, 2005, when I began my work, and as of March, 2006 when I concluded my examination of these files.

At present there are 320 files under review and eight under investigation.

Figure 3: Coroners Service Transition File Review
Status at Nov/05 and at March/06

Transition Files	As of November 2005	As of March 2006
Files reviewed by the Coroner	203	627
Files under Coroner review	40	320
Files under Coroner investigation	6	8
Files pending Coroner review	706	
Total	**955**	**955**

Conclusions

I am satisfied with the Coroners Service review of the 955 transition files.

The introduction of a comprehensive child death review protocol, the establishment of a specialized child death review unit, the review of all natural child deaths by a medical coroner, and the heightened focus on quality assurance of child death reviews have all been positive steps.

Of the 955 files, 627 investigations have been completed and judgments of inquiry issued; 320 are under review; and a further eight are under investigation by the Coroner. The Coroner intends to have all reviews completed by September, 2006, and will be issuing a public report in 2007.

The Coroners Service must complete its review of the remaining child deaths. Once complete, the data collected on the 955 child deaths should be aggregated and analyzed to add to our understanding not only of the child welfare system, but of the broader public health and prevention system.

The Coroners Service must use an external multidisciplinary team to review selected individual deaths, as well as trends and patterns, and to provide advice aimed at prevention.

The Representative for Children and Youth should, with the advice of a multidisciplinary team, consider the information collected in relation to the children in care, or who had been receiving, Ministry services. It should prepare a special report examining groupings of these deaths such as child suicides, homicides, drug-related deaths, and infant deaths, and provide advice and recommendations that can lead to improved service delivery and practice and prevent future deaths.

I say more about the ongoing role of the Coroner in child death reviews, in Chapter 2.

7

The Path from Here

THE PATH FROM HERE

- ☐ Dedicated Transition Team and Staff
- ☐ Representative for Children and Youth
- ☐ The Coroner
- ☐ The Ministry of Children and Family Development
- ☐ Budget, Staffing and Resource Implications

7. The Path from Here

I want to be very clear about the implementation of the changes recommended in this report, for the sake of those who may be obliged to engineer them. In doing so I recognize the risk of appearing overly prescriptive about the transition process, but in my defence I note that the last time the machinery of government made important changes in the child welfare system, things did not go well. In particular, the transfer of responsibility for child death reviews from the former Children's Commission to the Coroners Service was not planned or implemented to the standard that would be expected of such an important function.

7.1 DEDICATED TRANSITION TEAM AND STAFF

It will take the rest of the year to constitute the office of the Representative for Children and Youth, and this should be the first priority.

To undertake this work, I recommend the establishment of a full-time dedicated team with sufficient resources to do the job. A single Transition Manager should have lead responsibility, supported by an adequate complement of senior staff, to attend to the many moving parts that will comprise the transition process.

Foremost on the agenda will be the preparation of a detailed action plan, setting out what needs to happen, who is responsible for making it happen, timelines that need to be met, and the roles to be played by the other agencies of government that will be affected by the creation of the Representative for Children and Youth.

I assume as a matter of course that the Transition Manager will enjoy every form of assistance that can be provided by the Ministries of Children and Family Development, Public Safety and Solicitor General, including the Coroners Service, the Attorney General, and the Office for Children and Youth. A senior staff person from each of these agencies must be dedicated to working with the transition team and will be responsible for ensuring the required level of coordination and cooperation.

I also assume that the Ombudsman's Office and the Public Guardian and Trustee will actively support the building of the Representative for Children and Youth, and will work in partnership with it in the years to come.

The Transition Manager should report to the Deputy Attorney General. During the transition process, the Transition Manager should meet monthly with the Deputy Ministers of Attorney General, Children and Family Development, Public Safety and Solicitor General, with others attending as required.

I expect that these meetings would continue through the transition year. There should also be a regular public reporting of progress to the new model, to give the public confidence that matters are progressing apace.

7.2 REPRESENTATIVE FOR CHILDREN AND YOUTH

Because the Representative is to be an Officer of the Legislature, a special process will be required for the recruitment and selection. This should not delay the establishment of the office but it will not happen without cooperation from all parties.

I encourage the government to introduce legislation this year that will enable the establishment of this Office.

In establishing the new office, the Representative should conduct an open and transparent recruitment and selection process for new staff. Staff of the Office of Children and Youth will be given the opportunity to be considered for a position with the Representative.

7.3 THE CORONER

Once the new Representative for Children and Youth is established, the Coroner should refer to that office, for further review, any child deaths that occur during the transition period that meet the criteria for review by the Representative, as set out in Chapter 2.

7.4 THE MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT

As I write, key positions within the Ministry are held by men and women working under acting appointments. Earlier in this report I draw attention to what have been the serious costs of the revolving door at senior levels of the Ministry, as did Judge Gove in his review some years ago. I have recommended that whoever is finally appointed to the vacant positions be left in place for a minimum of four years. Five years would be better.

Paradoxically, the need for new leadership in the Ministry gives the government an opportunity to recruit individuals who are in tune with some of the needed changes the government itself has identified, and some of the changes identified in these pages.

I refer generally to the shift in the Ministry's traditionally authoritarian role, to one that is more collaborative, with new emphasis on the important roles of local services, communities and families in keeping children safe and well.

I refer also to the need for leadership in the more analytical side of the Ministry's important work, involving a range of activities from performance management to research, to stimulate what others have called "organizational learning."

The new leaders of the Ministry will soon find that some of my recommendations will require action on their part. Those recommendations are set out in these pages and require no further enumeration here. My only concern is that the agenda I have proposed will add to a workload that has overwhelmed the Ministry's management team in recent years.

At the same time, both government and the private sector have become more adept at managing change and I am confident that, with skilled leadership at all levels of the organization, the Ministry will meet its challenges.

7.5 BUDGET, STAFFING AND RESOURCE IMPLICATIONS

Some of my recommendations have implications for budget and staffing in the Ministry.

I endorse the direction taken in *Budget 2006* to substantially increase funding to "enhance existing programs and supports to care for and protect vulnerable children and youth, including child protection services and children in care."

The budget provides funding to hire more social workers and other front-line workers and to support various service initiatives, such as alternative dispute resolution processes (mediation and family group conferences) and additional resources for grandparents and other relatives looking after children under kith-and-kin agreements.
I support these directions.

I also commend the government for its foresight in assigning an additional $100 million to the child protection system over the next three years to address recommendations from this and other reviews.

That said, I caution that not all the challenges facing the Ministry can be addressed with funding. Simply reversing the funding lost is not a panacea. Skilled and competent leadership, with a clearly articulated vision for the future, is what is needed to manage the Ministry's agenda for change.

I would also like to make a comment about staffing. Front-line workers did not suffer from budget reductions to the extent that administration did, but we continue to lose social workers at a rate faster than they can be replaced. Demographics play a role—the aging of the workforce is by no means unique to this field—but it may have more to do with the nature of the work.

Child protection is not every social worker's first choice. Beyond the formal skills, the job requires toughness, warmth, intelligence, compassion, decisiveness and determination. It has been called the hardest job in government. When skilled workers have other choices, the Ministry will be challenged to find the continuing supply of people necessary to do this critical work.

I urge the Ministry to collaborate with colleges and universities and the BC Association of Social Workers, to plan and implement an occupational forecast to support the recruitment of young social workers and guide curriculum development, to ensure that we have the right number of social workers with the right skills to meet future demand.

I make specific recommendations and observations in this report that have implications for budget and staffing and resources in the Ministry:

A New Plan for External Oversight

- Establishing a new Representative for Children and Youth.
- Maintaining the Corners Service's focus on child death investigations and reviews.

Keeping Aboriginal Children Safe and Well

- Recruitment and retention of Aboriginal people for service in the Ministry.
- Support to Aboriginal delegated agencies for management development and service delivery.

Ministry for Children and Family Development

- Support for family support services, foster parents, and youth programs and services, including reintroduction of post-majority programs (transition to adulthood, for 19- to 24-year-olds).
- Support for reinvigorated campaign to recruit foster and adoptive parents.
- Support for required staffing, staff training and other resources associated with service transformation initiatives.

- Support for decentralization efforts, while maintaining a strong central agency capacity to ensure compliance with provincial standards by regions, and eventually authorities, and that the Ministry meets its responsibilities for public accountability.
- Development of performance measures including collaboration with other agencies involved in the child serving system.
- Ongoing support and maintenance of a strong quality assurance function, centrally, regionally, and in Aboriginal agencies.
- Establishment of, and ongoing support for, an effective complaint resolution process both in regions and at headquarters.
- External program evaluation for service transformation initiatives.

Communication and Coordination

- Enhanced statistical and public reporting of internal child injury and death reviews.
- Design, development and establishment of linked data sets by Ministry and Representative.

Appendices

APPENDICES

- ☐ Appendix A
Recommendations
- ☐ Appendix B
Interviewees and Public Submissions
- ☐ Appendix C
Ministerial Correspondence

Appendix A. – Recommendations

A.1 SUMMARY OF RECOMMENDATIONS

1. ***Recommendation***: That a Representative for Children and Youth be appointed as an Officer of the Legislature, for a five year term, renewable to a maximum of 10 years.
Reason: The status of an Officer of the Legislature, and a fixed term appointment, will give the public confidence in the office's independence.

2. ***Recommendation***: That the Legislature strike a new Standing Committee on Children and Youth, and that the Representative and Deputy Representatives report to this committee at least annually.
Reason: This all-party committee will contribute to a greater understanding among legislators and the public, of the province's child welfare system and will encourage Government and the Opposition to work together to address the challenges facing the system.

3. ***Recommendation***: That the Representative for Children and Youth be mandated to support and advise children, youth and families who need help in dealing with the child welfare system, and to advocate for change to the system itself.
Reason: Vulnerable children and families will always need someone to help them from time to time in their dealings with the child welfare system, and social workers too, often appreciate helpful interventions from the outside, on behalf of their clients.

4. ***Recommendation***: That the Representative for Children and Youth be mandated to monitor, review, audit and investigate the performance and accountability of the child welfare system, but that this mandate be reviewed in five years and revised as appropriate at that time.
Reason: It may not always be necessary to have an external body overseeing the functioning of the child welfare system, although at this time, the need for public confidence in the system demands it.

5. ***Recommendation:*** That the Representative be mandated to review certain child deaths and critical injuries. Reviews are to be limited to those children who were in care at the time, or who had been receiving Ministry services during the preceding year. The deaths and injuries to be reviewed are those due to abuse or neglect; or to an accident occurring in unusual or suspicious circumstances; or to self inflicted injury or injury inflicted by another; and only if the child welfare system might have contributed in some way to the death or injury. Critical injuries are those that are life-threatening, or cause serious or long term impairment.
Reason: Focusing child death review on child deaths where there is an apparent link to the child serving system will be a more productive use of the Representative's time and resources.

6. ***Recommendation:*** That legislation permit the Lieutenant Governor in Council or the Standing Committee to refer a death to the Representative, leaving it to the discretion of the Representative to determine whether to undertake a review or not, and to report to Cabinet.
Reason: There may be individual child deaths or critical injuries that have broader child welfare or social policy implications where a link to the child serving system is not readily apparent.

7. ***Recommendation:*** That the Representative have powers of a Commissioner of Inquiry under the Inquiry Act.
Reason: The Representative from time to time may need to compel evidence for the purposes of the review of a child death or injury.

8. ***Recommendation:*** That the Representative be mandated to report to the Minister, the Legislature and the public through annual reports and special reports. This reporting will include reporting on compliance with recommendations, by the Ministry and other public bodies.

Reason: Public reporting holds the Representative accountable to the Standing Committee, the Legislature as well as the public. Public reports can also promote improvements to the child serving system.

9. ***Recommendation***: That the Coroner's child death investigation function, with funding as reflected in Budget 2006 be continued.
Reason: The investigation and determination of the circumstances and cause of death is an important first step in the child death review function. The Coroners Service has addressed the particular challenges of investigating child deaths, with its child death protocol, and this will provide valuable information to the Ministry, the Representative, and others.

10. ***Recommendation***: That the Child Death Review Unit within the Coroners Service continue.
Reason: This unit is well-placed to ensure ongoing improvements to child death investigations through the maintenance of quality assurance standards, advice, consultation and training for local coroners.

11. ***Recommendation***: The *Coroners Act* should be updated, in line with the Coroner's role today; and expectations of the office should be clarified.
Reason: The role of the Coroner has changed over time and public accountability requires a better understanding on all sides of what is expected from the Coroners Service.

12. ***Recommendation***: That the provincial and federal governments, in collaboration with Aboriginal communities, begin work towards fulfillment of the commitments of the Kelowna Accord by assessing the health, economic and social needs of Aboriginal communities, including urban, off-reserve populations.
Reason: Needs assessments can form the basis of community plans for closing the gap in quality of life between Aboriginal and other British Columbians, which will mean stronger, safer families and communities for children.

13. ***Recommendation***: That the provincial government actively collaborate with Aboriginal people to develop a common vision for governance of the Aboriginal child welfare system; and whatever Aboriginal child welfare model evolves from that process must be the subject of active and widespread community consultation before its enactment.
Reason: Aboriginal people alone truly understand their communities and the needs of their children and families, so it makes sense that, with the support, expertise and experience of the Ministry, and working in partnership, their own wisdom and understanding should guide the way to any change in the governance structure of the child welfare system that serves them.

14. ***Recommendation***: That the provincial government work with Canada to clarify their respective funding responsibilities, remove jurisdictional obstacles facing Aboriginal child welfare agencies, and replace Directive 20-1 with a new approach that is more supportive of measures that protect the integrity of the family.
Reason: Agencies should be free to concentrate their efforts and resources on the important work they need to do in their communities, without unnecessary impediments caused by jurisdictional gaps, overlaps and conflicts and by funding formulas that do not support good child welfare practice.

15. ***Recommendation***: That the provincial and federal governments provide Aboriginal agencies with:
- modern information technology and help them acquire appropriate office management systems and skills;
- the same training opportunities as are offered to Ministry staff, as well as specialized training directed at their particular needs; and
- support during a crisis from an emergency response team.

Reason: Aboriginal agencies face many challenges in their work: to make effective use of scarce resources, they need to be supported by efficient office management and systems, and they need first rate professional skills. They also need special support at times of crisis, because small agencies cannot themselves provide for these rare events.

16. ***Recommendation***: That at least one of the three senior positions at the new Representative for Children and Youth be held at all times by an Aboriginal person; and that the Representative actively recruit some Aboriginal staff at all levels of the organization.
Reason: The new body must have Aboriginal people at senior levels if it is to be seen as truly accessible and credible to Aboriginal people, and, with a constituency that is at least half Aboriginal, can only be fully effective if it is guided by people with a true understanding of Aboriginal values, culture and communities.

17. ***Recommendation***: That the Ministry of Children and Family Development find ways to recruit and retain more Aboriginal people for service in the Ministry, at all levels, but particularly among social workers who deal directly with children and families.
Reason: The Ministry should reflect the cultural background of the people it serves and should be informed in its work with Aboriginal people by an understanding of child, family and community needs that comes from life experience.

18. ***Recommendation***: That the Ministry and community representatives jointly develop a plan for decentralization, beginning with a set of principles that will guide the process, a clear statement of expected results, and a course of action to achieve those results.
Reason: Without a vision and a plan of action, it is difficult to gain commitment and harness the requisite energy and resources to complete the task.

19. ***Recommendation***: That government commit itself to decentralization, which means supporting it with adequate resources, time, a dedicated team, and budget stability.
Reason: Decentralization is a complex process and cannot be successfully achieved without the necessary time, staff and resources.

20. ***Recommendation***: That responsibilities be transferred to regions and to Aboriginal authorities once they have demonstrated their ability to meet key performance targets.
Reason: Only by measuring performance will the Ministry be assured that the regional or Aboriginal authority has the capacity required to perform as required under a fully decentralized model.

21. ***Recommendation***: That the Ministry retain at its headquarters, the authority it needs to set and ensure compliance with provincial standards and to meet its responsibility for public accountability.
Reason: The Province retains ultimate responsibility for child welfare and must be accountable; British Columbians need to be assured of a consistent standard of service, wherever they live in the province, and whether they move from region to region.

22. ***Recommendation***: The Ministry should examine its management structure to find ways to realign roles and responsibilities in ways that will clarify lines of authority and facilitate collaboration across program areas and between regions and the central office.
Reason: Confusion about lines of authority is an impediment to effective services to children; and better integration of program areas will support decentralization and promote a more comprehensive approach to meeting all the needs of the children, youth and families that the Ministry serves.

23. ***Recommendation***: The Ministry should establish a comprehensive set of measures to determine the real and long-term impacts of its programs and services on children, youth and their families and then monitor, track and report on these measures for a period of time.
Reason: Measurements that are based on actual results will give the Ministry and the public a better understanding of the children and young people in its care, and what effects its programs are having on their lives.

24. *Recommendation*: The Ministry should continue its work with other BC ministries to establish common measures and linked data sets.
Reason: Combining the information available from a variety of sources will give the Ministry and the public a richer understanding of the children and families being served and the impact on their lives of wide range of government programs and services.

25. *Recommendation*: Once collected and analyzed, data must be used as a tool to support operational and management decision making, and program evaluation and policy development.
Reason: When programs and policies are introduced, the Ministry and the public need to understand the expected results for children; and after implementation, they need to be able to tell whether those results are being achieved.

26. Recommendation: The Ministry must devote sufficient resources to develop and maintain a strong central quality assurance function at headquarters, in the regions, and in Aboriginal agencies. In consultation with the regions and Aboriginal agencies, headquarters must set provincial standards; provide training, support and expertise; and monitor results.
Reason: A strong quality assurance framework is essential for consistency and accountability and to promote continuous improvements to policies, standards and practice across the system.

27. *Recommendation*: The Ministry needs to develop its capacity to do aggregate analysis of ***recommendation***s from case reviews and regional practice audits.
Reason: Aggregate analysis of recommendations that come from case reviews and audits closes the quality assurance loop by promoting continuous improvement of policy, standards and practice.

28. *Recommendation*: The Ministry needs a regular, coordinated program of reporting on its activities and results achieved for children in care and children at risk.
Reason: The Ministry accomplishes a great deal and has many successes: if they are not reported on a regular basis, the public forms its impression of Ministry performance and operations on the basis of media reports of rare but tragic events.

29. *Recommendation*: That the Ministry finalize, with a new sense of urgency, its complaint resolution process, ensuring that the process is timely, accessible, and simple; that it takes a problem-solving, rather than confrontational approach; and that it is respectful and responsive to the complainant; and that it involves the parties in resolving the issue.
Reason: An effective internal complaints resolution process can lead to better results for the children and families who are served by the child welfare system and can also lead to continuous improvement of the system itself.

30. *Recommendation*: That the Ministry develop processes for resolving complaints by Aboriginal children, youth and families that incorporate and respect traditional cultural values and approaches to conflict resolution.
Reason: Aboriginal cultures have approaches to conflict resolution that involve families and communities and cultural traditions, which can lead to resolutions that preserve relationships and promote healing.

31. *Recommendation*: That the Ministry adopt a common review tool to guide the conduct of cases reviews across all the program areas that are relevant to the life of a child who has died or been seriously injured.
Reason: Many children are served by several programs within the Ministry and only by looking at the role they all played in the child's life, can a true picture emerge. This broader view can form the basis for recommendations that will be more relevant and have more potential for prevention.

32. *Recommendation*: That the Ministry adjust its timelines for its internal reviews, ensuring timeliness, but taking account of current capacity. Once established, the timelines should be made public.
Reason: Timelines that are routinely disregarded because they cannot reasonably be met do not

encourage expeditious completion of these reviews. If reasonable timelines are established and published, the public can make realistic assessments of the Ministry's performance in completing its reviews.

33. *Recommendation*: That the Ministry undertake reviews of critical injuries and deaths of children receiving services from any of its program areas.
Reason: A focus on all child welfare services will provide a more complete picture of the role that Ministry services play in child injuries and deaths.

34. *Recommendation*: That the Ministry rename its internal injury and death reviews and clarify the scope of each.
Reason: "Deputy Director Review" and "Director's Case Review" lead to confusion about the nature of each. Public accountability requires more clarity and simplicity.

35. *Recommendation*: That the death or critical injury of a child who is in care always be subject to a review, regardless of the circumstances.
Reason: The Province is the guardian of the child and has a duty to ensure that all questions about the child's injury or death are answered, just as a caring parent would.

36. *Recommendation*: That the Ministry develop clear criteria to guide the decision as to whether to review the death or critical injury of children who are receiving or have received Ministry services.
Reason: Guidelines will promote consistent approaches to reviews and ensure that time and energy are focused on those cases that have the potential to lead to better protection for other children in the future.

37. *Recommendation*: That the Ministry review injuries and deaths not only of children who were receiving Ministry services at the time of the incident, but also of children who had received Ministry services during the 12 months preceding, and in exceptional circumstances, going back even further.
Reason: There may be important lessons to be learned even from cases where the child, for some *reason* was no longer receiving Ministry services.

38. *Recommendation*: That the Regional Executive Director be responsible to decide whether a review should occur; record the reasons for that decision; establish the terms of reference for the review; decide who will do the review; and finally, sign off on the recommendations that result.
Reason: The Regional Executive Director has ultimate responsibility for the Ministry's activities in the region and so needs to be accountable for the review process.

39. *Recommendation*: That the Provincial Director of child welfare retain the authority to conduct a review.
Reason: The Provincial Director has province-wide responsibilities. In some high profile or exceptional cases, the review may well be conducted jointly, or may be led by the Provincial Director.

40. *Recommendation*: That the Ministry provide required orientation, training and mentoring for practice analysts who will conduct reviews; and maintain a list of qualified reviewers.
Reason: This will support the regions and ensure a consistent quality of service across the province.

41. *Recommendation*: That the Ministry makes use of multidisciplinary teams in its child injury and death review process.
Reason: A team that brings together a broad spectrum of experience can contribute to a more thorough review and to the development of recommendations that speak to a wider range of services and public bodies.

42. *Recommendation*: That government provide sufficient funding, staffing and training to support its newer approaches to child protection work.

Reason: If these programs are to achieve their intended results, of better outcomes for children, they need to be adequately funded at the beginning, even if they will eventually result in cost savings and staff have to be trained to use them appropriately and effectively.

43. *Recommendation*: That an external evaluation of all programs under the service transformation initiative, beginning with kith and kin agreements, be undertaken both during the implementation phase and then later, on an ongoing basis.
Reason: Early evaluation can determine whether a program is being implemented in a way that is likely to realize its intended benefits; later evaluation can identify potential for minimizing risk and improving outcomes.

44. *Recommendation*: That program evaluation become a routine part of the Ministry's management role, to be carried out in consultation with the regions and with Aboriginal authorities, once established.
Reason: Evaluation provides the information on which sound management decisions can be based.

45. *Recommendation*: That government provide training for current social workers and recruit individuals with the necessary meditation and counselling skills to support the service transformation initiative.
Reason: The service transformation initiative calls for a skill set not traditionally required of social workers.

46. *Recommendation*: That the Ministry reinvigorate its campaign to recruit foster and adoptive parents and ensure that it is funded so that it can to respond to public interest and participation.
Reason: The Ministry's past recruitment campaign generated a level of interest that couldn't be serviced by the resources available at the time: with adequate resources, many new foster and adoptive families might be found.

47. *Recommendation*: That the Ministry establish a forum or council, including the new Representative for Children and Youth, the Coroners Service, the Ombudsman and the Public Guardian and Trustee, that will meet regularly to review developments and issues of common concern.
Reason: A forum that meets regularly will support communication and coordination between the Ministry and other bodies to ensure that developments and issues are brought to the forefront as they emerge, and will be a model for more collegial and collaborative approaches.

48. *Recommendation*: That the *Child, Family and Community Service Act*, which sets out powers and duties of the provincial Director be amended to include the power to produce reports of internal child death reviews and to state that although the main purposes of the report is learning, public accountability is a purpose of these reports.
Reason: This will clarify the Ministry's authority to conduct and publicly report on its case reviews

49. *Recommendation*: That the *Child, Family and Community Service Act* be amended to allow the Director to make information sharing agreements with other agencies for the purpose of multidisciplinary child death reviews.
Reason: This will allow other ministries, and other public bodies to fully participate with the Ministry in multidisciplinary child death reviews, with confidence that they have authority to share the information necessary for an effective and comprehensive review.

50. *Recommendation*: That the *Child, Family and Community Service Act* be amended to require the provincial Director to give, on a confidential basis, a complete copy of the final child death review report to all agencies that participated in a multi-disciplinary child death review team.
Reason: The multi-disciplinary review should also be a learning experience for the agencies that contribute to the death review, so it will be important for them to receive a full copy of the report.

51. *Recommendation*: That in its annual reports, the Ministry of Children and Family Development provide a statistical report of its reviews of deaths and critical incidents, as well as the

recommendations that resulted from those reviews, and a progress report on their implementation.
Reason: Statistical reports (without personal information) allow the public to become aware of developing trends. Reports of recommendations and their implementation will show the extent to which the lessons contained in the case reviews are being reflected in Ministry policy, procedures and practice.

52. *Recommendation*: That twice a year the Ministry of Children and Family Development publicly release a summary of each child death review it has completed during the previous six months. The summaries would contain no names, dates or places.
Reason: By reporting on groups of cases periodically (ideally, every six months), without identifying details, the Ministry can account to the public without undue delay, while protecting the privacy of children and families.

53. *Recommendation*: That if the death of a child who was in care or known to the Ministry has already been disclosed by police, a court or the Coroner, the Ministry be permitted by *the Child, Family and Community Service Act* to disclose the child's name and relationship to the Ministry and the contents of the Ministry's case review, to the extent necessary for accountability but without unreasonable invasion of privacy.
Reason: In high profile cases where information has been lawfully disclosed to the public, the Ministry needs to be publicly accountable for its actions. Because the provision would be permissive and not obligatory, the Ministry could decline to make any disclosure that could interfere with a criminal proceeding.

54. *Recommendation*: That the Representative for Children and Youth Act contain an authority to collect information that is at least equivalent to s.11 of the Office of Children and Youth Act; provisions to ensure that the records it requests are delivered promptly and without charge to the Representative; and to permit public disclosure of personal information if it is in the public interest, necessary to support the findings and recommendations, and not an unreasonable Invasion of privacy.
Reason: The Representative needs to have clear authority to obtain from other public bodies, who are subject to the Freedom of Information and Privacy Act, the information necessary to do the work required of the office. This information should be provided without charge because it is being used to further common goals—the safety and wellbeing of children and youth. It also needs the authority to report personal information, in limited circumstances, to fulfill its role in public accountability.

55. *Recommendation*: That the Representative *for Children and Youth Act* clearly provide for the creation, use and disclosure of linked data sets for purposes specified in the *Act*.
Reason: The Representative needs to collect and link data about children so that it can monitor and evaluate the effectiveness, responsiveness and relevance of services provided to children, youth and families.

56. *Recommendation*: That the Representative, in collecting linked data from Ministry of Children and Family Development and other public bodies for the purpose of fulfilling its monitoring role, develop policies and practices to ensure that all identifying information is removed from public reports and that the highest privacy standards are met; and
Reason: Linked data sets contain personal information from various sources, linked to identification of an individual and so are highly invasive of privacy. Therefore, they need to be used with great care and only when necessary for the benefit of the individual.

57. *Recommendation*: That the Ministry of Children and Family Development, in collecting linked data from other public bodies for the purpose of decision making about individuals, ensure that the absolute minimum information is collected and that each linking is necessary to enable the Director to deliver mandated services, and that the highest privacy standards are met.
Reason: Linked data sets contain personal information from various sources, linked to identification of

an individual and so are highly invasive of privacy. Therefore, they need to be used with great care and only when necessary for the benefit of the individual.

58. *Recommendation*: That the Representative for *Children and Youth Act* contain a provision similar to s.9 of the *Ombudsman Act*, requiring that information collected by the Representative be kept in confidence, with a limited right of disclosure.
Reason: The Representative will be collecting highly sensitive personal information, including linked data. The A confidentiality provision will ensure that personal information will only be disclosed in accordance with the statute.

59. *Recommendation*: That the Ministry of Children and Family Development should not rely on research agreements to collect and link personal information from other ministries and public bodies: it has the authority under *Child, Family and Community Service Act* s.96 to collect information and to use it to make decisions about individual children.
Reason: The Ministry should use the authority it has to gather data about children from Ministries of Health, Education, and others, and use it the way a parent would, to make decisions about individual children.

60. *Recommendation*: That the Ministry of Children and Family Development review the statutes that govern it to ensure that there are no statutory barriers to disclosure of information among program areas.
Reason: Many children are served by more than one program within the Ministry of Children and Family Development and their best interests often require that personal information about them be shared between programs. Ministry staff should be confident that they have the authority to share that information.

61. *Recommendation*: That the Ministry of Children and Family Development review its privacy policy documents to ensure that they are current, accurate and easily useable by employees.
Reason: Policy documents that are intended to guide employees need to be current and presented in a way that is easily useable by busy workers.

62. *Recommendation*: That the *Freedom of Information and Protection of Privacy Act* be amended to incorporate the "unreasonable invasion of privacy" test into s. 33.2, which authorizes public disclosure of personal information under certain conditions.
Reason: This would allow a public body to balance the need for public accountability with privacy interests in a way that is appropriate to the circumstances, by allowing a public body to disclose proactively the same information that could be disclosed in response to a formal access request.

Interview Participants And Submitters Acknowledgement

The Review would like to thank those who participated
in interviews and provided submissions.
They kindly shared their time, knowledge and very personal experiences
to enable a better understanding of the complex issues
around child and youth protection and advocacy in British Columbia.

Appendix B – Interviewees and Public Submissions

B.1 LIST OF INTERVIEW PARTICIPANTS

These people were interviewed in the course of the Review by the Honourable Ted Hughes and/or the Executive Director:

- John Greschner, Former Deputy, Children's Commission
- Paul Pallan, Former Commissioner, Children's Commission
- Joyce Preston, Former Advocate, Office of Child, Youth and Family Advocate
- Eric Jones, former Ombudsman Officer, Children's Commission Director and Gove Inquiry staffer
- Jane Morley, Child and Youth Officer, Province of British Columbia
- Cynthia Morton, First Commissioner, Children's Commission
- Terry Smith, Chief Coroner, with: Norm Leibel, Dr. Sid Pilley, Tej Sidhu and Colin Harris
- Alison MacPhail, Former Deputy Minister, Ministry of Children and Family Development
- Dr. Perry Kendall, Provincial Health Officer
- Howard Kushner, Ombudsman, with Bruce Ronayne, Director Investigations and Linda Carlson, Manager Investigations, Social Programs
- Bob Plecas, former Deputy Minister, Ministry of Children and Family Development
- Gillian Wallace, former Deputy Attorney General
- Jay Chalke, Public Guardian & Trustee of British Columbia with Catherine Romanko, Deputy Public Guardian & Trustee and Ed Berry (former MCFD worker for 17 years)
- Craig Meredith, Executive Director, Federation of Child and Family Services and Nanette Taylor, Director, Hollyburn Family Services
- Ian Mass, former Deputy Advocate, Office of the Child, Youth and Family Advocate

- Mike Eso, Patty Turner, Susan Powell, Cathy Seagris, Keith Cameron, Laurie Yeo and Gerry Karagiannis, BCGEU Representatives
- Teresa Lum and Nicole Herbert, Directors, Federation of BC Youth in Care Networks
- Chief Ed John, First Nations Summit
- Ross Dawson, former Director, Child Welfare
- Judge Thomas Gove
- David Morhart, Deputy Minister, Public Safety and Solicitor General
- Sandra Scarth, former Director of Children's Services in Ontario

Ministry of Children and Family Development senior management including:

- Lenora Angel, Assistant Deputy Minister, Aboriginal & Transition Services
- Alan Markwart, Assistant Deputy Minister, Provincial Services
- Jeremy Berland, former Assistant Deputy Minister
- Mark Sieben, Director, Regional Operations
- Cory Heavener, Director, Divisional Operations
- Ray Bronson, Quality Assurance Manager, Deputy Director, Aboriginal Services
- Donna Knox, Regional Executive Director, Vancouver Coastal
- Les Boon, Regional Executive Director, Fraser
- Doug Hayman, Regional Executive Director, Interior
- Peter Cunningham, Regional Executive Director, Northern
- Tom Weber, Regional Director, Vancouver Island and representing Anne Horan, Regional Executive Director, Vancouver Island Region)
- Linda O'Brien, Regional Director, Vancouver Coastal
- Bruce McNeill, Regional Director, Fraser
- John Waters, Regional Director, Interior

- Robert Watts, Regional Director, Northern
- Wayne Strelioff, Auditor General, and Morris Sydor, Deputy Auditor General
- John Mazure, Director, Economic Analysis, Martin Wright, Exec. Director, Strategic Policy & Planning and Kim Dandefer, Research Analyst, Ministry of Children and Family Development
- Jerry McHale, Assistant Deputy Minister, Justice Services Branch, Ministry of Attorney General
- Keith Hamilton, Gove Inquiry staffer
- Julie Dawson, Director, Aboriginal Services
- Dr. Jean Hlady and Adrienne Glenn, BC Children's Hospital
- Arn van Iersel, Acting Deputy Minister, Ministry of Children and Family Development
- Stephen Owen, Former Ombudsman, British Columbia
- David Loukidelis, Information and Privacy Commissioner for British Columbia
- Kelly MacDonald, Lavina White and Kathy Louis, Aboriginal Interests
- Bruce Brown, former Chief Investigator, Children's Commission
- Kim Henderson, Assistant Deputy Minister, Strategic Planning and Business Intelligence, Ministry of Children and Family Development
- Linda Burnside, Director, Authority Relations, Family Services and Housing, Province of Manitoba
- Mavis Henry, Executive Director, NIL/TU,O Child and Family Services Society
- John McDermott, Director, Collaborative Initiatives and Research Branch, Community Strategies and Support Division, Alberta Children's Services

B.2 LIST OF PUBLIC SUBMISSIONS

Representatives of Groups

Board of Directors, Network of East Vancouver, Community Organizations

Lynne Dyson, Director, Developmental Disabilities Association

Ray Chapman, President, Board of Registration for Social Workers

Theo Boere, Executive Director, Nanaimo Men's Resource Centre

Deryck Thomson, Administrator, BC Family & Children's Services (retired)

Betty Cornelius, President, Cangrands Kinship Support

Derek Hansom, Youth Participation Coordinator, Child &Youth Officer, Province of British Columbia

Kim Lyster, Executive Director, Penticton & District Community Resources Society

Joseph Rosen, President *and* Jessica Chant, Executive Director, Society for Children & Youth of BC

Jocelyn Helland, Community Liaison, International Institute for Child Rights and Development

Wendy Barker, Administrator, Powell River Child, Youth & Family Service Society

Connie Matchatis, Chair, First Nations Child & Family Service Agency Directors Forum

David Dundee, Chair, Kamloops Family Law, Subsection Canadian Bar Assn., BC Branch

Cecelia Klassen, Family Network for Deaf Children

Jay Chalke, Public Guardian and Trustee of British Columbia

Teresa Lum *and* Nicole Herbert, Directors, Federation of BC Youth in Care Networks

Ruth Annis, Executive Director, Pacific Community Resources Society

Teresa Mayhew, ICYS Program Director, St. Leonard's Youth Family Services

Dr. John Taylor, Clinical Director, Connexus Family & Children Services

Howard Kushner, Ombudsman, Province of British Columbia

Sarah Boyd-Noel, Coordinator, Northern Women's Centre Society of UNBC

Alanna Hendren, Executive Director, Developmental Disabilities Association

Craig Meredith, Executive Director, Federation of Child & Family Services of BC

Melanie Scott, Director, Xyolhemeylh Child & Family Services

Deborah Frolek, Executive Director, Kamloops Child Development Centre

Ken Emery, FASD Support Network of BC

Petra Sinats, Respite Care Coordinator, Young Parents Support Network

Linda Korbin, Executive Director, BC Association of Social Workers

Tyrone McNeil, Vice President, Sto:lo Tribal Council

Susan Henry, First United Church Mission

Dr. Jerry Arthur-Wong, Executive Director, BC Men's Resource Centre

Sheila Durnford, President, BC Federation of Foster Parent Associations

Warner Adam, President, BC Aboriginal Child Care Society

Sheila Davidson, Child & Youth Advocate, City of Vancouver

Sharon Saxon, Coordinator, Hazelton Child and Youth Care Services

Ralph Hembruff, Executive Director, Boys & Girls Club Services of Greater Victoria

Mike Eso, Staff Representative, BCGEU

Northern Aboriginal Association for Families

Lillian George, President, United Native Nations

Jerry Adams, Executive Director, Urban Native Youth Association

Adrianne Montani, Provincial Coordinator, First Call BC Child & Youth Advocacy Coalition

Christine Peterson, Associate Child and Youth Officer, Province of British Columbia

Anita Dadson, President, BC FamilyNet Board of Directors

Mark Benton, Executive Director, Legal Services Society

Steve Bouchard, on behalf of Board of Directors, Ray-Cam Co-operative Centre

Individuals

Dr. Maple Melder Crozier, Professor
Child & Youth Care
University College of the Fraser Valley

Ian Martin, MD, CCFP, ASAM
UBC Dept of Family Practice

Dr. Clyde Hertzman, Director
Human Early Learning Partnership, UBC

Monica Angus, Ph.D., R. Psychologist
(retired)

Riley Hern, Child Protection Team Leader
(retired)

Dr. Jason Walker, Former Deputy Regional Coroner *and* MaryLynne Rimer, Former Deputy Children's Commissioner, Programs

Roger Tonkin, MDCM, FRCPC, OBC
Professor Emeritus, UBC

John Cossom, professor emeritus
Social Work, UVic

John Lane, Deputy Chief of Police (retired)
City of Victoria

Edward Kruk, MSW, Ph. D.
Associate Prof, UBC

Brian Wharf, professor emeritus
Social Work, UVic

Adrian Dix, MLA (Vancouver Kingsway) Children and Family Development Critic

Eric Jones
Thomas Feakins
Scott Robinson
Laurie Edberg
Wilma Millette
Gail Taylor
Josef Fisher

Kathy Berggren-Clive
Brian Bleakney
Mary Miller
Maureen Wint
Cindy Carson
David Schreck
Cindy McKnight

Robert & Rose White
Basil Boulton, MD, FRCP (Pediatrics)
Sarah Chandler, MA
Ken Berg
Lene Goetzinger
Jean Preece
Carol Fyfe-Wilson

Colleen Friesen
Lisa Haeck
Bonnie Kupser
Judi Lucas
Dawn Steele
Tiny MacDonald
Denis Gagnon
Sandra Green
Eduarda Martel
Kent & Suzanne Israel
Rowena Eloise
Anonymous
Anonymous
Mrs. D. Wulff
Beth Berlin
Gige Blais
Ms Antoinette Shawara
M. John Simpson
Elena Elliot
Rod Barrett
Wilda Robinson
Jeannie Lynch
Anonymous
Janice Watt
Danny & Maureen Weston
Ron Skoros
Natexa Verbrugge
Maureen Balcaen
Scott Denoon
Christine Jarchow
Greg Cross
Brenda Herrin
Dr. Shannon Moeser
Bruce Nelson
M. Kiwani
Garnet Stephen
Christine Armstrong-Smith
Gordon Hogg
Jerry McHale
Anonymous
Heather Hegan
William Robertson
Sue
Leona Sherlock
Mrs. Audrey Hanssen
Chrystall Craig
Arlene McEwen
Anonymous
Brenda Brown
Sue Halstead
Doug Morrison
Bonnie Breckenridge
Patrick Wayne Nesbitt
Susan Schwarz
Marie Wise
Angeline Rohrig
Marlee Sales
Rita Scott
Dr. Brian Habbick
Jon Kittle
Sarah Smith
Bonnie Kennedy
Geraldine Wesley
Susanne Dannenberg
Carol Simpson
Stewart Alcock
Willow Cerridwyn
Mrs. Jean Bain
Joy Wilson
Patti Tooke
Janine Stockford
Peter Griffiths
Anonymous
Darlene Murphy
Jane Usher
Sheila Kaye
Mike Day
Patricia Hergt
Bernice Edward
Leisa Ballard
Cheryl
Sharon Casey
Laura Jones
Elsie Anderson
Claire Marie Belanger
Selena Witt
Beverley J Knowles
Margaret Pearson
Kathleen Stephany
Gary Day
Dawn-Marie Tytherleigh
Gerry Masuda
Tracey Young
Del Phillips
Joan Miller
Mike Stewart
Kat Szabo
Jade Mclaren
Dr. Mychael Gleeson
R. Lee Curtis
Jonathon van der Goes
Rev. Val Anderson
Patricia Keene
Marlene Trick
Gregory and Marion Staple
Heather Johnson
Jamie Ager
Philippa Ostler
Jane Wolverton
Beth Finley
Dulcie McCallum
Vivian Hicks
Sheila Bradshaw
John Nesbitt

Sue Keast
Sandra Scarth
Shelly Dewar
Ian Sparshu
Kathy Louis
Stuart Miller
Alison Dennis
Kate Bechmann
Lila Parsons
Sue Reid
W J Matsubuchi
Kathleen Dupuis
Helga Godfrey
Ray Ferris
Laurie Esson
Jane Coombe
Sheri A Burrows
Steve Arnett
Peter Davidson
Anonymous
Anonymous
Anonymous
Dave Arnell
Elaine Moonen
Geoffrey Hodder
Anonymous
Eileen Benedict
Alison Dennis
Anonymous

Michael Olson
Kimberly Murray
Chief Wayne Christian
Louise Schmidt
Suzanne
Regina Day
Kemp Redl
Marnie Mutch
Brad Morgan
Laura Yake
Jerad Dennis
Sharon Sinclair
William Boggs
Anonymous
Anonymous
Sue Luoma
Gwen Struthers
Susanna Kaljur
Bernice Schatz
Mary Clohosey
Alexis Petersen
Robert Lundberg
Gretchen Zinkan
Anonymous
Andrea Rolls
Lex Reynolds
Sue Devlin
Lana McQuarrie
Anonymous

Judy Sims
Anonymous
Lana McQuarrie
Graeme J A Moore
Yvonne Laviolette
Elio Azzara
Forrest Nelson
Laura Hoelzley-Barrow
Peter Siu
Jane Coombie
Shelby Harvey
Leona Marchand
Mrs. Lorette Cerise Firlotte
Christopher J Van Twest
Joanell Clarke
Anonymous
Gisella Ruebsaat
June Preston
Anonymous
Angela Mezzatesta
Anonymous
Anonymous
Dr. Clare Moisey
Anonymous
Charlotte Ray
Pat Nowazek
Noreen
Anonymous

Appendix C. – Ministerial Correspondence

C.1 - Correspondence: Dec 14, 2005 page 1, 2

From: Hon. John Les, Solicitor General, Ministry of Public Safety and Solicitor General

Subject: Child Death Review Investigation

C.2 - Correspondence: Jan 6, 2006 page 1, 2, 3

From: Hon. Ted Hughes

Subject: BC Children and Youth Review

C.3 - Correspondence: Jan 31, 2006 page 1, 2

From: Hon. John Les, Solicitor General, Ministry of Public Safety and Solicitor General

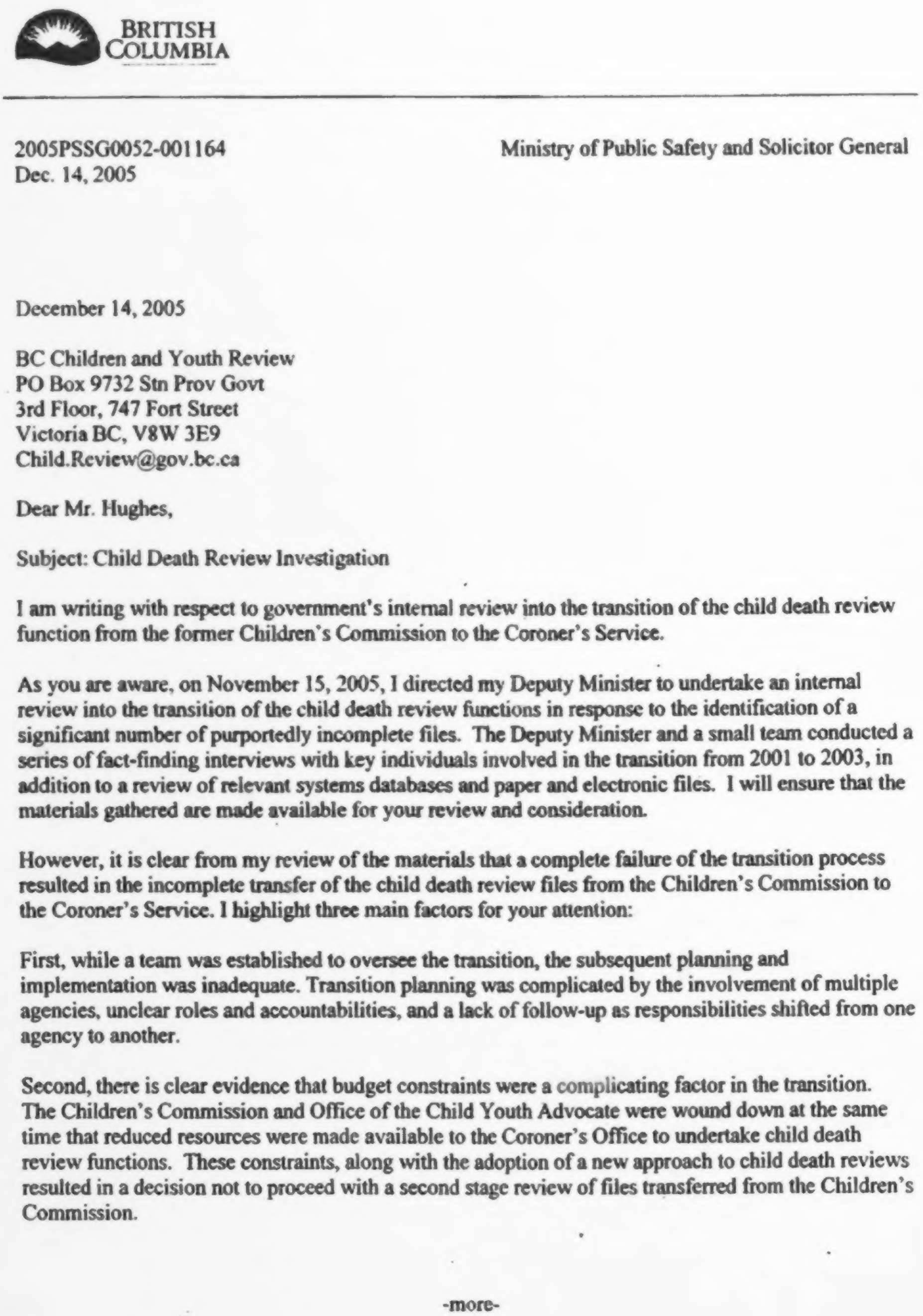
Subject: BC Children and Youth Review – Response

C.4 - Correspondence: Feb 10, 2006 page 1

From: Hon. Ted Hughes

Subject: BC Children and Youth Review – Response

C.1 CORRESPONDENCE: DEC 14, 2005 - PAGE 1, 2



BRITISH COLUMBIA

2005PSSG0052-001164
Dec. 14, 2005

Ministry of Public Safety and Solicitor General

December 14, 2005

BC Children and Youth Review
PO Box 9732 Stn Prov Govt
3rd Floor, 747 Fort Street
Victoria BC, V8W 3E9
Child.Review@gov.bc.ca

Dear Mr. Hughes,

Subject: Child Death Review Investigation

I am writing with respect to government's internal review into the transition of the child death review function from the former Children's Commission to the Coroner's Service.

As you are aware, on November 15, 2005, I directed my Deputy Minister to undertake an internal review into the transition of the child death review functions in response to the identification of a significant number of purportedly incomplete files. The Deputy Minister and a small team conducted a series of fact-finding interviews with key individuals involved in the transition from 2001 to 2003, in addition to a review of relevant systems databases and paper and electronic files. I will ensure that the materials gathered are made available for your review and consideration.

However, it is clear from my review of the materials that a complete failure of the transition process resulted in the incomplete transfer of the child death review files from the Children's Commission to the Coroner's Service. I highlight three main factors for your attention:

First, while a team was established to oversee the transition, the subsequent planning and implementation was inadequate. Transition planning was complicated by the involvement of multiple agencies, unclear roles and accountabilities, and a lack of follow-up as responsibilities shifted from one agency to another.

Second, there is clear evidence that budget constraints were a complicating factor in the transition. The Children's Commission and Office of the Child Youth Advocate were wound down at the same time that reduced resources were made available to the Coroner's Office to undertake child death review functions. These constraints, along with the adoption of a new approach to child death reviews resulted in a decision not to proceed with a second stage review of files transferred from the Children's Commission.

-more-

Third, there were inadequate data-record and reporting systems. Each of the Children's Commission, the Coroner's Service, the Office of the Child and Youth Officer, and the Ministry of Children and Family Development use unique electronic systems that do not communicate or share information with each other. As such, each agency operates in some isolation from the others, leading to potential inconsistent approaches on specific cases and inevitable duplication of efforts.

Over the past several months, the ministries and agencies involved have undertaken several initiatives to improve information sharing and to ensure that they work in tandem for the betterment of children overall.

With respect to the Ministry of Public Safety and Solicitor General specifically, we have taken a number of steps to address the resource challenges of the Coroner's Service. In Spring 2005, an additional $1.4 million was added to the budget of the Coroner's Office, in part to address ongoing child death review responsibilities. The reporting relationship of the Chief Coroner was changed in October 2005 from reporting to a program assistant deputy minister to reporting directly to the Deputy Solicitor General. Third, additional resources were provided in late October to address increasing caseload volumes and to provide critical analytical support. Also, as a result of the internal review, we are adding additional coroner resources to manage these newly identified demands. Lastly, we have begun the work of extracting and reviewing the offsite files as well as building one comprehensive database to support the child death review function within the Coroner's Service.

I believe that it is now appropriate to transfer these materials to you for completion of my Deputy's investigation, preparation of recommendations to prevent future failures of this nature, and any further action as you see fit. If you wish to undertake your own series of interviews to corroborate these findings, I can assure you that you will have the full cooperation of the staff of the Coroner's Service, the Deputy Solicitor General, and other ministry staff in providing the support that you require.

Yours truly,

Hon John Les
Solicitor General

.pc Hon Wally Oppal
Hon Stan Hagen
Hon Gordon Campbell

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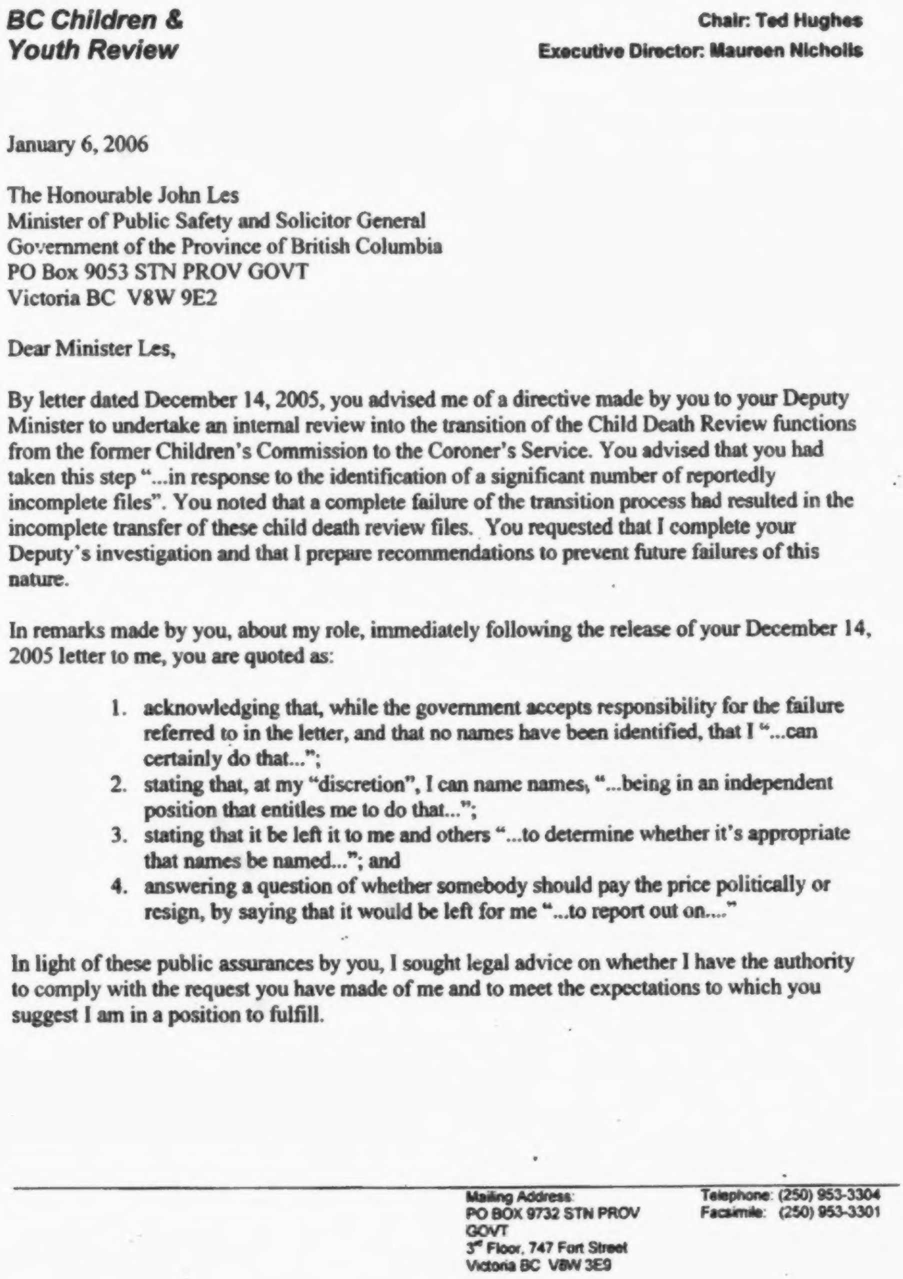
C.2 CORRESPONDENCE: JAN 6, 2006 - PAGE 1, 2, 3



*BC Children &
Youth Review*

Chair: Ted Hughes
Executive Director: Maureen Nicholls

January 6, 2006

The Honourable John Les
Minister of Public Safety and Solicitor General
Government of the Province of British Columbia
PO Box 9053 STN PROV GOVT
Victoria BC V8W 9E2

Dear Minister Les,

By letter dated December 14, 2005, you advised me of a directive made by you to your Deputy Minister to undertake an internal review into the transition of the Child Death Review functions from the former Children's Commission to the Coroner's Service. You advised that you had taken this step "...in response to the identification of a significant number of reportedly incomplete files". You noted that a complete failure of the transition process had resulted in the incomplete transfer of these child death review files. You requested that I complete your Deputy's investigation and that I prepare recommendations to prevent future failures of this nature.

In remarks made by you, about my role, immediately following the release of your December 14, 2005 letter to me, you are quoted as:

1. acknowledging that, while the government accepts responsibility for the failure referred to in the letter, and that no names have been identified, that I "...can certainly do that...";
2. stating that, at my "discretion", I can name names, "...being in an independent position that entitles me to do that...";
3. stating that it be left it to me and others "...to determine whether it's appropriate that names be named..."; and
4. answering a question of whether somebody should pay the price politically or resign, by saying that it would be left for me "...to report out on...."

In light of these public assurances by you, I sought legal advice on whether I have the authority to comply with the request you have made of me and to meet the expectations to which you suggest I am in a position to fulfill.

Mailing Address:
PO BOX 9732 STN PROV GOVT
3rd Floor, 747 Fort Street
Victoria BC V8W 3E9

Telephone: (250) 953-3304
Facsimile: (250) 953-3301

I sought that advice from Paul J. Pearlman, Q.C., of the Victoria law firm of Fuller Pearlman McNeil. Mr Pearlman has advised me that:

(i) *In our view, you do not have the legal authority to subpoena, or otherwise compel the attendance of witnesses for your review. Nor do your terms of reference contemplate you making findings of fault or misconduct against individuals. You have not been appointed as a commissioner under the Inquiry Act, R.S.B.C. 1996, c. 224, and therefore do not have the power to summon witnesses provided by the Act.*

(ii) *The Minister of Children and Family Development appointed you to conduct an independent review of the child protection system, in order to examine and make recommendations for improvement to the particular aspects of that system itemized under paragraph 1(a), (b) and (c) of Part I, and paragraph 1(a) and (b) of Part II of your terms of reference.*

For the purposes of your review under Part I, you are authorized to consider the roles and responsibilities of the Ministry, and the various public officers and agencies involved in the child protection system. However the focus of that review is to make recommendations for improvements to the system.

Your terms of reference do not provide that you may inquire into, or make findings of misconduct regarding the performance of individuals involved in specific child death review cases.

In my opinion, your power, under paragraph 2 of Part I, to consider "any related matters" that you see fit, enables you to examine and make recommendations regarding matters relating to the improvement of the system for child death reviews, advocacy for children and youth, and monitoring of the government's performance. While this would include identifying reasons why the existing systems or structures have failed, or areas where there is room for improvement, your terms of reference do not, either expressly, or by implication, provide you with authority to inquire into, and make adverse findings regarding the conduct of individuals in particular cases.

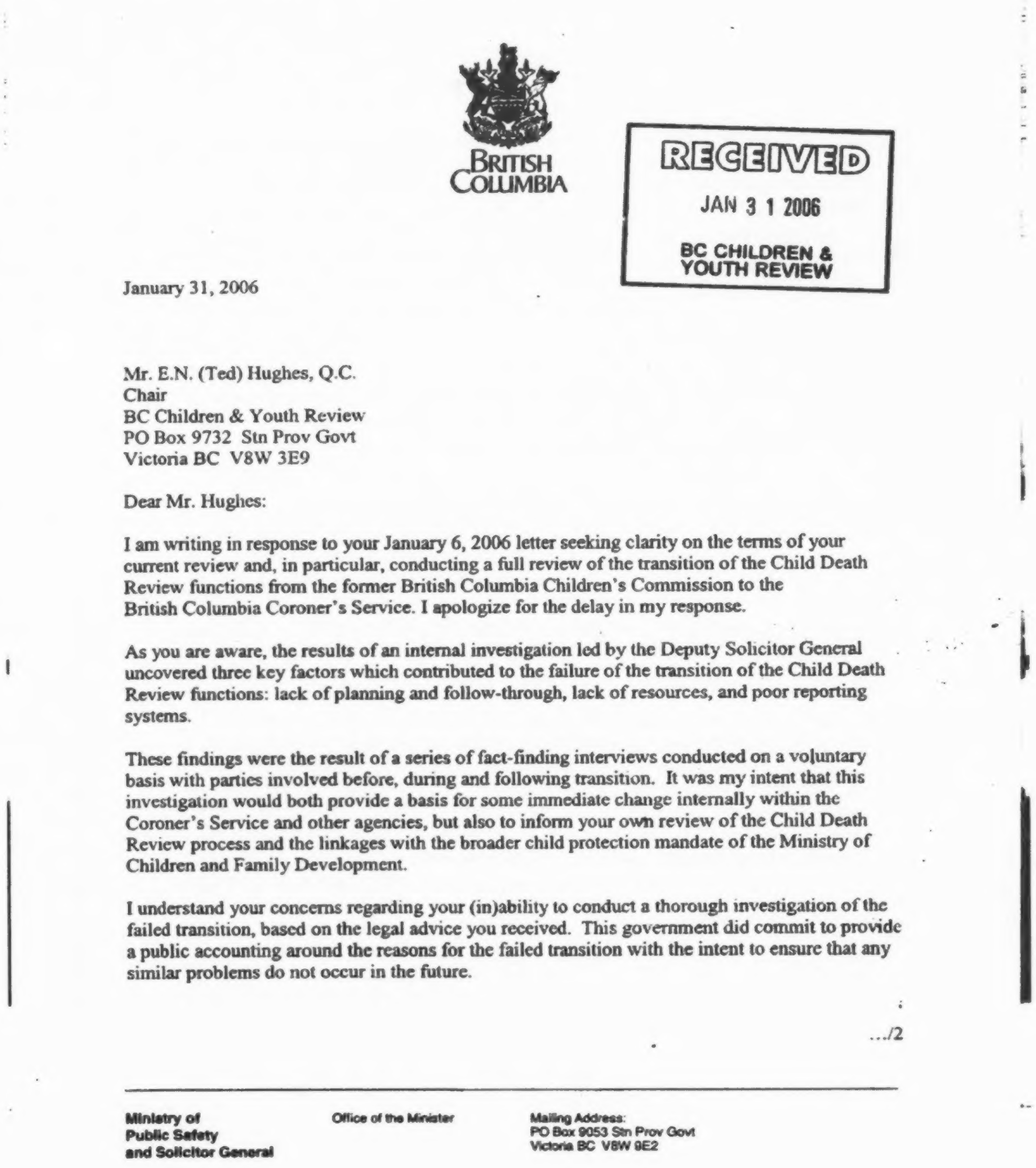
(iii) *Even if this were a commission of inquiry, as opposed to an independent review requested by the Minister, in the absence of clear and unequivocal language conferring the power to inquire into misconduct, your terms of reference would not authorize you to do so.*

In my judgment, the advice that Paul J. Pearlman has given to me, which I accept, refutes your public assurances of December 14, 2005 and brings into question my authority to proceed as you have asked, given the terms of reference of my current assignment. Having come to that conclusion, I thought I ought to communicate it to you at this time.

Sincerely,

Ted Hughes, Q.C.
Chair
BC Children & Youth Review

C.3 CORRESPONDENCE: JAN 31, 2006 - PAGE 1, 2



BRITISH
COLUMBIA

RECEIVED
JAN 31 2006
BC CHILDREN &
YOUTH REVIEW

January 31, 2006

Mr. E.N. (Ted) Hughes, Q.C.
Chair
BC Children & Youth Review
PO Box 9732 Stn Prov Govt
Victoria BC V8W 3E9

Dear Mr. Hughes:

I am writing in response to your January 6, 2006 letter seeking clarity on the terms of your current review and, in particular, conducting a full review of the transition of the Child Death Review functions from the former British Columbia Children's Commission to the British Columbia Coroner's Service. I apologize for the delay in my response.

As you are aware, the results of an internal investigation led by the Deputy Solicitor General uncovered three key factors which contributed to the failure of the transition of the Child Death Review functions: lack of planning and follow-through, lack of resources, and poor reporting systems.

These findings were the result of a series of fact-finding interviews conducted on a voluntary basis with parties involved before, during and following transition. It was my intent that this investigation would both provide a basis for some immediate change internally within the Coroner's Service and other agencies, but also to inform your own review of the Child Death Review process and the linkages with the broader child protection mandate of the Ministry of Children and Family Development.

I understand your concerns regarding your (in)ability to conduct a thorough investigation of the failed transition, based on the legal advice you received. This government did commit to provide a public accounting around the reasons for the failed transition with the intent to ensure that any similar problems do not occur in the future.

.../2

**Ministry of
Public Safety
and Solicitor General**

Office of the Minister

Mailing Address:
PO Box 9053 Stn Prov Govt
Victoria BC V8W 9E2

Consequently, I believe that a review of and comment by you on the reasons for the failed transition, including preventative recommendations for the future, are an important component of your broader review into British Columbia's child protection system.

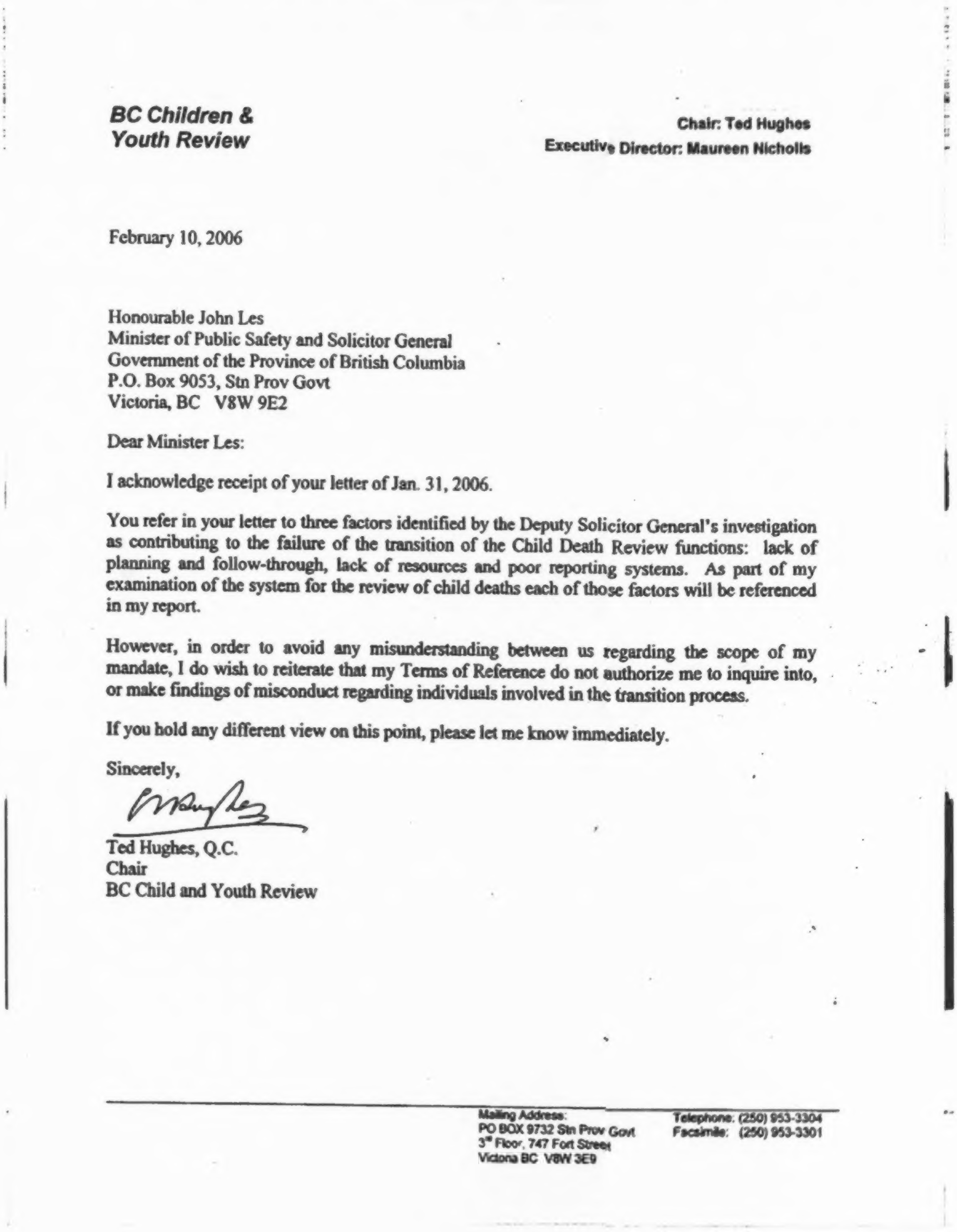
I appreciate the work that you and your team are doing to validate and improve upon the integrity of the child protection services in the Province of British Columbia.

Yours truly,

John Les
Solicitor General

pc: The Honourable Gordon Campbell
The Honourable Wally Oppal
The Honourable Stan Hagen

C.4 CORRESPONDENCE: FEB 10, 2006 - PAGE 1



BC Children &
Youth Review

Chair: Ted Hughes
Executive Director: Maureen Nicholls

February 10, 2006

Honourable John Les
Minister of Public Safety and Solicitor General
Government of the Province of British Columbia
P.O. Box 9053, Stn Prov Govt
Victoria, BC V8W 9E2

Dear Minister Les:

I acknowledge receipt of your letter of Jan. 31, 2006.

You refer in your letter to three factors identified by the Deputy Solicitor General's investigation as contributing to the failure of the transition of the Child Death Review functions: lack of planning and follow-through, lack of resources and poor reporting systems. As part of my examination of the system for the review of child deaths each of those factors will be referenced in my report.

However, in order to avoid any misunderstanding between us regarding the scope of my mandate, I do wish to reiterate that my Terms of Reference do not authorize me to inquire into, or make findings of misconduct regarding individuals involved in the transition process.

If you hold any different view on this point, please let me know immediately.

Sincerely,

Ted Hughes, Q.C.
Chair
BC Child and Youth Review

Mailing Address:
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Victoria BC V8W 3E9

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